

6621

CERTIFICATE OF DEATH

06598

Reg. Dist. No.

| | | | | | | | |
|--|--|-------------------------------------|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly, Md.</u> | | | | c. LENGTH OF STAY IN 1b <u>9 Days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General Hospital</u> | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landover Md.</u> | | | |
| | | | | d. STREET ADDRESS <u>5621 Landover Road</u> | | | |
| | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Girl</u> Last <u>Ammonn</u> | | | | 4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>19 57</u> | | | |
| 5. SEX <u>female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>June 20 1957</u> | |
| | | | | 9. AGE (In years lost birthday) <u>9 Days</u> | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | |
| | | | | 11. BIRTHPLACE (State or foreign country) <u>Cheverly Md</u> | | | |
| 13. FATHER'S NAME <u>Clyde E. Ammonn</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Ada V. Beall</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. ----- | | 17. INFORMANT <u>Ada (Mother) Ammonn</u> | |
| | | | | Address <u>Same as above</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal Obstruction</u> 756.2 DUE TO <u>Congenital atresia of duodenum - jejunal junction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>from birth</u> DUE TO <u>11 11</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>6-23-1957</u> to <u>6-28-1957</u> , that I last saw the deceased alive on <u>6-28-1957</u> , and that death occurred at <u>3:20 AM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Dr. Geo H. McLain</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>1746 K St. N.W.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Dr. Geo H. McLain</u> | | | | DATE SIGNED <u>WAS H-67D.C</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6/29/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Ammondale Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Ammondale, Maryland.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>James March's Sons</u> | | | | ADDRESS <u>14739 Baltimore Hgts, Md</u> | | 24a. REC'D BY REGISTRAR <u>JUL 3 57</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6622

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 14, 8, & 22C Film G-217 7/1/57 CERTIFICATE OF DEATH

Reg. Dist. No. 06599

| | | | | | | | |
|--|---------------------------|---|---------------------------------------|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE MD b. COUNTY PG | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY ATTSTVILLE | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 HYATTSVILLE | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEO. GEN HOSP | | | | e. STREET ADDRESS 6903-18 AVE | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last HAROLD M. ANDERSEN | | | | 4. DATE OF DEATH Month Day Year JUNE 10 1957 | | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1903 10-17-02 | 9. AGE (In years last birthday) 54 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. COAST GUARD | | 10b. KIND OF BUSINESS OR INDUSTRY MARINE AGR | | 11. BIRTHPLACE (State or foreign country) Wisconsin | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Gunder Andersen | | | | 14. MOTHER'S MAIDEN NAME unknown Ellen Marie Evenson | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mr. Harold J. Andersen 1121 N. Bynum St. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 ACUTE HEART FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ACUTE MYOCARDIAL INFARCTION DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 HOURS 7 DAYS 1 MONTH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. Month. Day. Year 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from JUNE 3, 1957 , to JUNE 10, 1957 , that I last saw the deceased alive on JUNE 10, 1957 , and that death occurred at 2 P.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Samuel J. Sugar | | | | ADDRESS (Street, city or town, state) MILWAUKEE, WI | | | |
| PHYSICIAN'S NAME (Type) SAMUEL J. N. SUGAR, M.D. | | | | DATE SIGNED 6/10/57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE THEREOF 6/12/57 | | 22c. NAME OF CEMETERY OR CREMATORY Forest Lawn Cemetery | | 22d. LOCATION (City, town, or county) (State) Milwaukee, Wisconsin | |
| 23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Company Washington, D.C. | | | | 24a. REC'D BY REGISTRAR June 12 57 | | 24b. REGISTRAR'S SIGNATURE Qu... | |

CERTIFICATE OF DEATH

WESTLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

Form No. 10

| | | | |
|--|--|--|--|
| <p>1. NAME OF DECEASED [Faint text]</p> | | <p>2. SEX [Faint text]</p> | |
| <p>3. AGE [Faint text]</p> | | <p>4. DATE OF BIRTH [Faint text]</p> | |
| <p>5. PLACE OF BIRTH [Faint text]</p> | | <p>6. DATE OF DEATH [Faint text]</p> | |
| <p>7. CAUSE OF DEATH [Faint text]</p> | | <p>8. PLACE OF DEATH [Faint text]</p> | |
| <p>9. SIGNATURE OF DECEASED [Faint text]</p> | | <p>10. SIGNATURE OF WITNESS [Faint text]</p> | |
| <p>11. SIGNATURE OF DECEASED [Faint text]</p> | | <p>12. SIGNATURE OF WITNESS [Faint text]</p> | |
| <p>13. SIGNATURE OF DECEASED [Faint text]</p> | | <p>14. SIGNATURE OF WITNESS [Faint text]</p> | |
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| <p>17. SIGNATURE OF DECEASED [Faint text]</p> | | <p>18. SIGNATURE OF WITNESS [Faint text]</p> | |
| <p>19. SIGNATURE OF DECEASED [Faint text]</p> | | <p>20. SIGNATURE OF WITNESS [Faint text]</p> | |
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| <p>97. SIGNATURE OF DECEASED [Faint text]</p> | | <p>98. SIGNATURE OF WITNESS [Faint text]</p> | |
| <p>99. SIGNATURE OF DECEASED [Faint text]</p> | | <p>100. SIGNATURE OF WITNESS [Faint text]</p> | |

BUREAU V. 3

JUN 12 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar to burial, cremation, or removal.

6692

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06600
Reg. Dist. No.

| | | | | | | | |
|--|------------------------------------|---|---|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE D.C. b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale | | c. LENGTH OF STAY IN 1b transient | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47 X-3 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Baltimore- Washington Parkway | | | | d. STREET ADDRESS 2224- 1st Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Nealy James Anderson | | | | 4. DATE OF DEATH Month Day Year June 9 1957 | | | |
| 5. SEX Male | 6. COLOR OR RACE colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH January 22, 1929 | | 9. AGE (in years last birthday) 28 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lubrication man | | 10b. KIND OF BUSINESS OR INDUSTRY Auto. service. | | 11. BIRTHPLACE (State or foreign country) S. Carolina | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Nealy Alexander | | | | 14. MOTHER'S MAIDEN NAME Carrie Anderson | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes. Korean War | | 16. SOCIAL SECURITY NO. 219-40-4260 | | 17. INFORMANT Address Mrs. J.M. McClurkin; same address. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Severence of thoracic aorta DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of an automobile in collision with another automobile | | | | | |
| 20c. TIME OF INJURY Month, Day, Year 11:50 P.M. 6-8-57 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway | | 20f. (City or town) (County) (State) Glenn Dale, Pr. Geo. Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Noturol causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE John T. Maloney | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) John T. Maloney, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER Re June 9, 1957 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) 6/11/57 | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) SPARTANSBURG S.C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE FRAZAR'S FUNERAL HOME 389 RT | | | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE JUN 12 '57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE | | | |

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|-------------------------------|--|----------------------|--|
| Name of deceased | | John A. Jones | |
| Residence | | 1234 - 1st Street | |
| Age | | 25 | |
| Sex | | Male | |
| Color | | Caucasian | |
| Occupation | | Auto. service | |
| Cause of death | | Hemorrhage and shock | |
| Place of death | | Home | |
| Date of death | | June 12, 1957 | |
| Time of death | | 10:30 P.M. | |
| Signature of physician | | J. A. Jones | |
| Signature of medical examiner | | J. A. Jones | |

BUREAU V. S.

JUN 12 1957

RECEIVED

6623

CERTIFICATE OF DEATH

06601

Reg. Dist. No.

| | | | | | | | |
|---|---------------------------|---|---------------------------------|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MD b. COUNTY PG | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Kent Village | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Gen Hosp | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Neva F Anderson | | | | 4. DATE OF DEATH Month Day Year June 4, 1957 | | | |
| 5. SEX Female | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH bet 9, 1900 | 9. AGE (In years last birthday) 56 yrs. | 10. IF UNDER 1 YEAR Months Days Hours Min. | 11. IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY own Home | | 11. BIRTHPLACE (State or foreign country) south Dakota | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A | | | | | | | |
| 13. FATHER'S NAME Charles A. Horning | | | | 14. MOTHER'S MAIDEN NAME Ella Ross | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | | | 16. SOCIAL SECURITY NO. — | | | |
| 17. INFORMANT Marion L. Anderson | | | | Address Kent village Md | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Massive interventricular hemorrhage DUE TO (b) Essential hypertension DUE TO (c) 10 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 444X INTERVAL BETWEEN ONSET AND DEATH 12 hrs | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from 6/4, 1957, to 6/4, 1957, that I lost saw the deceased olive on 6/4, 1957, and that death occurred at 8:20 AM, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE John Kehoe | | | | ADDRESS (Street, city or town, state) 3404 Cheverly ave Cheverly Md | | | |
| DATE SIGNED 1/4/57 | | | | | | | |
| PHYSICIAN'S NAME (Type) JOHN KEHOE | | | | Cheverly Md | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial June 6, 1956 | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY Arlington National | | 22d. LOCATION (City, town, or county) Arlington Pa | |
| 23. FUNERAL DIRECTOR'S SIGNATURE F Buschi sons Hyattsville Md | | | | 24a. REC'D BY REGISTRAR JUN 10 57 | | 24b. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|--|--|---|--|
| 1. NAME OF DECEASED <i>John Doe</i> | | 2. SEX <i>Male</i> | |
| 3. AGE <i>45</i> | | 4. RACE <i>White</i> | |
| 5. DATE OF DEATH <i>June 10, 1957</i> | | 6. PLACE OF DEATH <i>Home</i> | |
| 7. TIME OF DEATH <i>10:00 AM</i> | | 8. CAUSE OF DEATH <i>Heart Disease</i> | |
| 9. DISEASE OR INJURY <i>Myocardial Infarction</i> | | 10. MANNER OF DEATH <i>Natural</i> | |
| 11. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i> | | 12. SIGNATURE OF DEATH REGISTRAR <i>John Doe</i> | |
| 13. SIGNATURE OF WITNESS <i>John Doe</i> | | 14. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 15. SIGNATURE OF WITNESS <i>John Doe</i> | | 16. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 17. SIGNATURE OF WITNESS <i>John Doe</i> | | 18. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 19. SIGNATURE OF WITNESS <i>John Doe</i> | | 20. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 21. SIGNATURE OF WITNESS <i>John Doe</i> | | 22. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 23. SIGNATURE OF WITNESS <i>John Doe</i> | | 24. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 25. SIGNATURE OF WITNESS <i>John Doe</i> | | 26. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 27. SIGNATURE OF WITNESS <i>John Doe</i> | | 28. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 29. SIGNATURE OF WITNESS <i>John Doe</i> | | 30. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 31. SIGNATURE OF WITNESS <i>John Doe</i> | | 32. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 33. SIGNATURE OF WITNESS <i>John Doe</i> | | 34. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 35. SIGNATURE OF WITNESS <i>John Doe</i> | | 36. SIGNATURE OF WITNESS <i>John Doe</i> | |
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| 39. SIGNATURE OF WITNESS <i>John Doe</i> | | 40. SIGNATURE OF WITNESS <i>John Doe</i> | |
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| 43. SIGNATURE OF WITNESS <i>John Doe</i> | | 44. SIGNATURE OF WITNESS <i>John Doe</i> | |
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| 49. SIGNATURE OF WITNESS <i>John Doe</i> | | 50. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 51. SIGNATURE OF WITNESS <i>John Doe</i> | | 52. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 53. SIGNATURE OF WITNESS <i>John Doe</i> | | 54. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 55. SIGNATURE OF WITNESS <i>John Doe</i> | | 56. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 57. SIGNATURE OF WITNESS <i>John Doe</i> | | 58. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 59. SIGNATURE OF WITNESS <i>John Doe</i> | | 60. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 61. SIGNATURE OF WITNESS <i>John Doe</i> | | 62. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 63. SIGNATURE OF WITNESS <i>John Doe</i> | | 64. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 65. SIGNATURE OF WITNESS <i>John Doe</i> | | 66. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 67. SIGNATURE OF WITNESS <i>John Doe</i> | | 68. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 69. SIGNATURE OF WITNESS <i>John Doe</i> | | 70. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 71. SIGNATURE OF WITNESS <i>John Doe</i> | | 72. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 73. SIGNATURE OF WITNESS <i>John Doe</i> | | 74. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 75. SIGNATURE OF WITNESS <i>John Doe</i> | | 76. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 77. SIGNATURE OF WITNESS <i>John Doe</i> | | 78. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 79. SIGNATURE OF WITNESS <i>John Doe</i> | | 80. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 81. SIGNATURE OF WITNESS <i>John Doe</i> | | 82. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 83. SIGNATURE OF WITNESS <i>John Doe</i> | | 84. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 85. SIGNATURE OF WITNESS <i>John Doe</i> | | 86. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 87. SIGNATURE OF WITNESS <i>John Doe</i> | | 88. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 89. SIGNATURE OF WITNESS <i>John Doe</i> | | 90. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 91. SIGNATURE OF WITNESS <i>John Doe</i> | | 92. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 93. SIGNATURE OF WITNESS <i>John Doe</i> | | 94. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 95. SIGNATURE OF WITNESS <i>John Doe</i> | | 96. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 97. SIGNATURE OF WITNESS <i>John Doe</i> | | 98. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 99. SIGNATURE OF WITNESS <i>John Doe</i> | | 100. SIGNATURE OF WITNESS <i>John Doe</i> | |

BUREAU V. 2

JUN 10 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item PM3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

6624

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06602

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b D.O.A. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 33 Bladensburg | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital | | | | d. STREET ADDRESS 4104 53rd Avenue | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) James | | First Harvey | | Last Baird | | 4. DATE OF DEATH Month June Day 23 Year 19 57 | |
| 5. SEX Male | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 9-23-36 | |
| 9. AGE (In years last birthday) 20 yrs. | | IF UNDER 1 YEAR Months 20 Days 20 Hours 20 Min. 20 | | IF UNDER 24 HRS. Months 20 Days 20 Hours 20 Min. 20 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic | | | | 10b. KIND OF BUSINESS OR INDUSTRY Virginia | | 11. BIRTHPLACE (State or foreign country) U S A | |
| 12. CITIZEN OF WHAT COUNTRY? U S A | | | | | | | |
| 13. FATHER'S NAME Harvey Lee Baird | | | | 14. MOTHER'S MAIDEN NAME Mary M Jones | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT Mother ; same address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Crushed chest and lacerated wound of abdomen Conditions, if any, which gave rise to immediate cause (b) Crushed chest and lacerated wound of abdomen (a), stating the underlying cause lost. (c) Crushed chest and lacerated wound of abdomen | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Crushed chest and lacerated wound of abdomen | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Collision of automobile with an embankment | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour 10.35 P.m. 6-23 1957 | | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway | | 20f. (City or town) (County) (State) Glenn Dale, Pr. Geo. Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE John T. Maloney | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) John T. Maloney, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/26/57 | | 22c. NAME OF CEMETERY OR CREMATORY St Andrews | | 22d. LOCATION (City, town, or county) (State) Buckingham Co Va | |
| 23. FUNERAL DIRECTOR'S SIGNATURE F Gasch's sons Hyattsville Md | | | | 24a. REC'D BY REGISTRAR June 27 57 | | 24b. REGISTRAR'S SIGNATURE Paul Smith | |

MD
68-1
MAYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

JUN 27 1957

RECEIVED

6625

CERTIFICATE OF DEATH

06603

Reg. Dist. No.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges | | | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | | c. LENGTH OF STAY IN lb 1 da. 19 hr. | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland | | | | b. COUNTY Prince Georges | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant | | | | | | | | | | | | | | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | d. STREET ADDRESS 6815 EADS Street | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Adelaide FLORENCE Barnes | | | | 4. DATE OF DEATH Month Day Year June 25 1957 | | | | 5. SEX Female | | | | 6. COLOR OR RACE White | | | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH 5-24-78 | | | | 9. AGE (In years last birthday) 79 yrs. | | | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) asst. Chief | | | | 11. BIRTHPLACE (State or foreign country) Washington D.C. | | | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | |
| 13. FATHER'S NAME Joseph W. Palmer | | | | 14. MOTHER'S MAIDEN NAME Mary Steele | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. Unknown | | | | 17. INFORMANT Madelyn Stewart | | | | Address 1610 - Myrtle St. N.W. | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute myocardial infarct DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary arterio sclerosis. DUE TO (c) Generalized arterio sclerosis. | | | | | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0 | | | | | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21. I certify that I attended the deceased from Jan 10 , 19 50 , to June 25 , 19 57 , that I last saw the deceased alive on June 25 , 19 57 , and that death occurred at 10:30 M, from the causes and on the date stated above. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE William Brainin | | | | ADDRESS (Street, city or town, state) 6124 Central Ave | | | | DATE SIGNED 6/25/57 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PHYSICIAN'S NAME (Type) WM BRAININ | | | | Capitol Bldg. Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 22b. DATE THEREOF 6-28-57 | | | | 22c. NAME OF CEMETERY OR CREMATORY Washington Natl. | | | | 22d. LOCATION (City, town, or county) (State) Seat Pleasant, Maryland | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chamber to | | | | ADDRESS 577-11th St. N.E. | | | | 24a. REC'D BY REGISTRAR DATE JUN 28 '57 | | | | 24b. REGISTRAR'S SIGNATURE W. W. Chamber to | | | | | | | | | | | | | | | | | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
 SEX: [illegible] AGE: [illegible]
 DATE OF BIRTH: [illegible]
 PLACE OF BIRTH: [illegible]
 OCCUPATION: [illegible]
 CAUSE OF DEATH: [illegible]
 PLACE OF DEATH: [illegible]
 DATE OF DEATH: [illegible]
 TIME OF DEATH: [illegible]
 SIGNATURE OF PHYSICIAN: [illegible]
 SIGNATURE OF REGISTRAR: [illegible]

RECEIVED
 JUN 28 1957
 BUREAU V. S.

6626

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---------------------------|---|---------------------------------|
| 1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b 34 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 (Hyattsville P.O.) University Hills | |
| f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | d. STREET ADDRESS X 2822 3402 Notre Dame St. | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Carl M Bavone | | 4. DATE OF DEATH Month Day Year June 23 19 57 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6 June 1908 |
| 9. AGE (In years last birthday) 49 | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer Government | | 10b. KIND OF BUSINESS OR INDUSTRY Government | |
| 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Fred Bavone | | 14. MOTHER'S MAIDEN NAME Emilia Poli | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. W W 11 | |
| 17. INFORMANT Lena A Bavone | | Address 3402 Notre Dame St University Hills, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of</u> 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adenocarcinoma of Stomach</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 year | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from August 56, to June 22, 19 57, that I last saw the deceased alive on June 22, 19 57, and that death occurred at 5:30 A.M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Leon Lawrence Gallin M.D. | | ADDRESS (Street, city or town, state) 7206 Cokeville Rd University Hills Md | |
| DATE SIGNED 6/23/57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/26/56 | |
| 22c. NAME OF CEMETERY OR CREMATORY St. Bernards Cemetery | | 22d. LOCATION (City, town, or county) (State) Indiana Pennsylvania | |
| 23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md. | | 24a. REC'D BY REGISTRAR DATE JUN 26 57 | |
| 24b. REGISTRAR'S SIGNATURE Overhach | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9

BUREAU V. B.

JUN 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6627

CERTIFICATE OF DEATH

06605

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|--|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> | | | | c. LENGTH OF STAY IN 1b <u>15</u> Hyattsville, Md. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u> | | | | d. STREET ADDRESS <u>4216 Jefferson St</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>William</u> First <u>Beatty</u> Middle Last | | 4. DATE OF DEATH <u>June</u> Month <u>14</u> Day <u>1957</u> Year | | | | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec 20 1875</u> | 9. AGE (In years lost birthday) <u>81</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u> | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Samuel J. Beatty</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Annie E. Wise</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no. or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Namie L Beatty</u> Address <u>Hyattsville, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTRACEREBRAL Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>cerebral Arteriosclerosis</u> DUE TO (c) <u>generalized Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>5 yrs</u> <u>5 yrs</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u> | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>MARCH 31</u> , 19 <u>57</u> , to <u>JUNE 14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>JUNE 14</u> , 19 <u>57</u> , and that death occurred at <u>11:30</u> PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3503 Perry ST</u> DATE SIGNED <u>6/14/57</u> ACTUAL SIGNATURE <u>Norman Donat Comeau</u> M.D. <u>MT RAINIER MD</u> PHYSICIAN'S NAME (Type) <u>NORMAN DONAT COMEAU</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6/17/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Colmar Manor Maryland.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Maryland.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>JUN 19 57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Ob. 1957</u> | |

BUREAU OF THE ARMY

JUN 19 1957

RECEIVED

6628

CERTIFICATE OF DEATH

| | | | | | | | |
|---|----------------------------|---|---------------------------------------|---|--|---|--|
| 1. PLACE OF DEATH o. COUNTY <u>Bowie George</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Mont.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Providence</u> | | | | c. LENGTH OF STAY IN 1b <u>3 hrs.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Sidland Memorial Hosp</u> | | | | d. STREET ADDRESS <u>4316 Willow Lane</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Linda J. Blackistone</u> | | | | 4. DATE OF DEATH <u>6</u> Month <u>21</u> Day <u>1957</u> Year | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 15, 1955</u> | 9. AGE (In years last birthday) <u>1</u> yrs. | IF UNDER 1 YEAR Months <u>11</u> Days <u>6</u> | IF UNDER 24 HRS. Hours <u></u> Min. <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u> | | 11. BIRTHPLACE (State or foreign country) <u>Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Zachariah Blackistone</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Harriet J. Atwell</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>Zachariah D. Blackistone-Same Item #2</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>481X</u> DUE TO <u>Upper Respiratory Infection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>24 hr</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>June 17</u> , 19 <u>57</u> , to <u>June 21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 21</u> , 19 <u>57</u> , and that death occurred at <u>3:35</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>311 Thos. Drive, Laurel, Md.</u> DATE SIGNED <u>6/21/1957</u> | | | | | | | |
| ACTUAL SIGNATURE <u>Robert C. Wingfield</u> M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>Robert C. Wingfield</u> | | | | 311 Thos. Drive, Laurel, Md. 6/21/1957 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6/25/1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u> | | 22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert C. Wingfield Bethesda Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>JUN 26 1957</u> | | 24b. REGISTRAR'S SIGNATURE <u>James H. Jones</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

| | | | |
|------------------------|--|-----------------------|--|
| NAME OF DECEASED | | DATE OF DEATH | |
| JAMES EARL RAY | | JUN 26 1968 | |
| AGE | | SEX | |
| 35 | | Male | |
| RACE | | EDUCATION | |
| White | | High School | |
| BIRTH DATE | | BIRTH PLACE | |
| JAN 5 1933 | | Memphis, Tennessee | |
| MARRIAGE DATE | | MARRIAGE PLACE | |
| None | | None | |
| OCCUPATION | | CAUSE OF DEATH | |
| None | | Suicide by gunshot | |
| MANNER OF DEATH | | PLACE OF DEATH | |
| Suicide | | Memphis, Tennessee | |
| CERTIFICATE NO. | | REGISTRATION NO. | |
| 10000000000000000000 | | 10000000000000000000 | |
| SIGNATURE OF REGISTRAR | | SIGNATURE OF DECEASED | |
| [Signature] | | [Signature] | |
| DATE OF REGISTRATION | | DATE OF DEATH | |
| JUN 26 1968 | | JUN 26 1968 | |

BUREAU V. E.

JUN 26 1968

RECEIVED

311 Union Ave, Baltimore

Report of Death

10000000000000000000

10000000000000000000

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

6629

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66607

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Dist. of Col. b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b 10 hours | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Robert Frank Blasdell | | 4. DATE OF DEATH Month Day Year June 24 19 57 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 20, 1931 |
| 9. AGE (In years last birthday) 25 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plastic engineer | | 10b. KIND OF BUSINESS OR INDUSTRY U.S.Bu. of Ships | |
| 11. BIRTHPLACE (State or foreign country) Michigan | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Vernell G. Blasdell | | 14. MOTHER'S MAIDEN NAME | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) Korean | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Beverly Blasdell; Same address | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fractured skull DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Rider of a motorcycle which overturned throwing him to the pavement | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 12.35 PM 6-23-57 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway | | 20f. (City or town) (County) (State) Riverdale Pr. Geo. Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE John T. Maloney | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) John T. Maloney, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED June 24, 1957 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/27/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Washington National | | 22d. LOCATION (City, town, or county) (State) Washington D.C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE F. Gosels Sone Hyattsville, Md. | | ADDRESS | |
| 24a. REC'D BY REGISTRAR JUN 26 '57 | | 24b. REGISTRAR'S SIGNATURE Alb. Beach | |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

1994-1995 20-25 20-25

204 *Journal of*

501 East Street, N.Y.

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Verheul, G. Hendrik.

Review: Richard J. ...

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Table 60 (cont.)

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BUREAU OF THE ARMY

JUN 26 1957

RECEIVED

6630

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|-----------------------------------|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGES COUNTY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) b. STATE MD. c. COUNTY PRINCE GEORGES | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY | | | | c. LENGTH OF STAY IN 1b × 2 SEAT PLEASANT | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGES GEN. HOSP. | | | | d. STREET ADDRESS 7004 ROLAND RIDGE DRIVE | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First JOHN Middle WILLIAM Last BOWEN | | | | 4. DATE OF DEATH Month JUNE Day 16 Year 19 57 | | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1-5-57 | | 9. AGE (In years lost birthday) yrs. 5 | IF UNDER 1 YEAR Months 11 Days 11 | IF UNDER 24 HRS. Hours 11 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Washington D.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John William Bowen | | | | 14. MOTHER'S MAIDEN NAME Dolores Welsh | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT John William Bowen 7004-Rolling Ridge Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital heart failure 754.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cir. Insultation & I.V. pyofur DUE TO (c) Defect & abnormal. entrance & Pul. Ven into rt atrium PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Dr. | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from 6/16 , 19 57 , to 6/16 , 19 57 , that I last saw the deceased alive on 6/16 , 19 57 , and that death occurred at 1:50 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE Max W. Herzberg M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) MAX HERZBERG | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| Burial | | 6-19-57 | | Cedar Hill Cem. | | Swittard, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers, S.E. | | | | 24a. REC'D BY REGISTRAR W.W. Chambers | | 24b. REGISTRAR'S SIGNATURE W.W. Chambers | |
| | | | | DATE JUN 18 57 | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06699

6631

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 4 FilmG217 7-1-57 et.

Reg. Dist. No.

| | | | |
|--|-----------------------------|--|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Penna. b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg, Md. | | c. LENGTH OF STAY IN 1b 7 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3011 Kenilworth Avenue | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Philadelphia 75 X-3 | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Deloris Breland | | 4. DATE OF DEATH Month Day Year June 20, 1957 | |
| 5. SEX female | 6. COLOR OR RACE colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 25, 1940 |
| 9. AGE (In years last birthday) 17 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | 10b. KIND OF BUSINESS OR INDUSTRY school | |
| 11. BIRTHPLACE (State or foreign country) Washington D. C. | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Joe Breland | | 14. MOTHER'S MAIDEN NAME Idell Hines | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT Idell Breland Philadelphia Penna. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Universal 3rd and 4th degree burns of body (c) Conflagration in home DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Overcome by smoke and burned by fire in home. | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 20-57 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | | 20f. (City or town) (County) (State) Hyattsville P.O. Pr. Geo. Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE John T. Maloney | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) John T. Maloney, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED June 20, 1957 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-26-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Crestwood National Cemetery | | 22d. LOCATION (City, town, or county) (State) Washington D.C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Baron | | 24. REC'D BY REGISTRAR DATE 27 1957 | |
| 24b. REGISTRAR'S SIGNATURE H. H. Adrich | | | |

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|--------------------------|--|--------------------------|--|---------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | |
| 4. OCCUPATION | | 5. MARITAL STATUS | | 6. PLACE OF BIRTH | |
| 7. DATE OF DEATH | | 8. TIME OF DEATH | | 9. PLACE OF DEATH | |
| 10. CAUSE OF DEATH | | 11. MANNER OF DEATH | | 12. SIGNATURE OF EXAMINER | |
| 13. SIGNATURE OF WITNESS | | 14. SIGNATURE OF CORONER | | 15. SIGNATURE OF JURY | |

Book

16. Description of body

17. Cause of death

18. Manner of death

19. Signature of examiner

20. Signature of witness

21. Signature of coroner

22. Signature of jury

BUREAU V. S.

JUN 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for use in connection with the burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

6632

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 FilmG218 8-1-57 et

CERTIFICATE OF DEATH

06610

Reg. Dist. No. 245

| | | | |
|--|---------------------------|---|----------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale Md | | c. LENGTH OF STAY IN 1b 10 years | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 25 Riverdale Md. | | d. STREET ADDRESS 1 6107 63rd Avenue,. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6107 63rd Avenue,. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Winfield S Middle Brickerd Last | | 4. DATE OF DEATH Month June Day 10, 19 57. | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug 26 |
| 9. AGE (In years low birthday) yrs. 76 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Tile Setter | | 10b. KIND OF BUSINESS OR INDUSTRY self | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Isaac Brickerd | | 14. MOTHER'S MAIDEN NAME Sidney ? | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. no | |
| 17. INFORMANT Ida A Brickerd | | Address Riverdale, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive Heart Failure, (c) arterio sclerotic Heart Disease - 6 yrs. | | INTERVAL BETWEEN ONSET AND DEATH Sudden death 6 weeks | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4341 | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 7, 1957, to June 10, 1957, that I last saw the deceased alive on June 7, 1957, and that death occurred at 12:45 PM, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE L W Malin M.D. | | DATE SIGNED June 10, 1957 | |
| PHYSICIAN'S NAME (Type) L W Malin M.D. | | ADDRESS (Street, city or town, state) Riverdale, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/13/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery | | 22d. LOCATION (City, town, or county) (State) Colmar Manor, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons | | ADDRESS Hyattsville, Md. | |
| 24a. REC'D BY REGISTRAR JUN 14 1957 | | 24b. REGISTRAR'S SIGNATURE James Levesey | |

JUN 14 1957

BUREAU V. B.

6633

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>PRINCE GEORGES</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>41 Laurel</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PRINCE GEORGES</u> | | d. STREET ADDRESS <u>1 36-4th STREET</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Ambrose E. Brown</u> | | 4. DATE OF DEATH Month Day Year <u>June 2 1957</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11-11-75</u> |
| 9. AGE (In years lost birthday) <u>81</u> yrs. | | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pakeman, Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Dist of Columbia</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>New Jersey</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME <u>unknown</u> | | 14. MOTHER'S MAIDEN NAME <u>unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give year or dates of service) <u>none</u> | | 16. SOCIAL SECURITY NO. <u>yes-</u> | |
| 17. INFORMANT <u>Mrs Achsah Brown</u> Address <u>3rd 4th st Laurel, Md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>generalized Arteriosclerosis</u> DUE TO <u>Hypertensive Cardio Vascular Disease</u> (c) <u>10 years</u> 10 years | | INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>10 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>332 X</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>5/31</u> , 1957, to <u>6/2</u> , 1957, that I last saw the deceased alive on <u>6/2</u> , 1957, and that death occurred at <u>3:57</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Norman Donat Omeau</u> M.D. <u>3503 Penny St</u> | | DATE SIGNED <u>7/2/57</u> | |
| PHYSICIAN'S NAME (Type) <u>NORMAN DONAT OMEAU</u> | | <u>MT RAINIER MD.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>6-5-57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Gaithersburg, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co</u> ADDRESS <u>Riverdale, Maryland</u> | | 24a. REC'D BY REGISTRAR DATE <u>JUN 6 '57</u> 24b. REGISTRAR'S SIGNATURE <u>W. H. Leach</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 6 1957

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6634

CERTIFICATE OF DEATH

06612

Reg. Dist. No.

| | | | | | | | |
|--|------------------------------------|--|--------------------------------------|---|---|--|------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PR. GEO.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BLADENSBURG</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BLADENSBURG</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS <u>14116-51ST STREET</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>SARAH E. BUTLER</u> | | | | 4. DATE OF DEATH Month <u>JUNE</u> Day <u>30</u> Year <u>1957</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>COLORED</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3-19-1904</u> | 9. AGE (In years last birthday) <u>53</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>UNKNOWN</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>CHAS. HEBBURN</u> | | | | 14. MOTHER'S MAIDEN NAME <u>CATHERINE JACKSON</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>CHARLES H BUTLER</u> Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mycocarditis</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Hypertenson</u> DUE TO (c) | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH <u>2 Yrs</u> <u>5 Yrs</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>422.2</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a. <u>11</u> p. m. Month, Day, Year <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from <u>6/10</u> , 19 <u>57</u> to <u>6/30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/28</u> , 19 <u>57</u> , and that death occurred at <u>10</u> <u>A</u> .M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Leonard Hays</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>H yattsville Md.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Leonard Hays M.D.</u> | | | | DATE SIGNED | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>7/3/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Memorial</u> | | 22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles Hays</u> | | | | ADDRESS <u>30 H Street, N.E.</u> | | 24a. REC'D BY REGISTRAR DATE <u>JUL 2 '57</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Al Search</u> | | | |

CERTIFICATE OF DEATH

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED <i>JOHN E. BROWN</i> | | 2. SEX <i>Male</i> | |
| 3. AGE <i>45</i> | | 4. DATE OF BIRTH <i>1912</i> | |
| 5. PLACE OF BIRTH <i>Baltimore, Md.</i> | | 6. OCCUPATION <i>Engineer</i> | |
| 7. MARITAL STATUS <i>Married</i> | | 8. DATE OF MARRIAGE <i>1935</i> | |
| 9. NAME OF SPOUSE <i>John E. Brown</i> | | 10. DATE OF DEATH <i>1957</i> | |
| 11. PLACE OF DEATH <i>Baltimore, Md.</i> | | 12. CAUSE OF DEATH <i>Heart Disease</i> | |
| 13. MEDICAL HISTORY <i>None</i> | | 14. SIGNATURE OF PHYSICIAN <i>[Signature]</i> | |
| 15. SIGNATURE OF REGISTRAR <i>[Signature]</i> | | 16. OFFICIAL USE | |

BUREAU V. S.

JUL 2 1957

RECEIVED

6635

CERTIFICATE OF DEATH

06613

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince George MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY Prince George | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md. | | | | c. LENGTH OF STAY IN 1b 1 Day | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 7112- Allison St. | | | | d. STREET ADDRESS Landover Hills, Md | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Maggie Middle A. Last Causey | | | | 4. DATE OF DEATH Month June Day 8 Year 19 57 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Feb 4, 1874 | |
| 9. AGE (In years last birthday) 83 yrs. | | IF UNDER 1 YEAR Months 8 Days 12 Hours 57 Min. | | IF UNDER 24 HRS. Months 8 Days 12 Hours 57 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY own home | | 11. BIRTHPLACE (State or foreign country) North Carolina | |
| 12. CITIZEN OF WHAT COUNTRY? U S A | | | | | | | |
| 13. FATHER'S NAME David Aiken | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Mrs Eula Rutledge Landover Hills, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 24 hrs. DUE TO (c) | | | | INTERVAL BETWEEN ONSET AND DEATH 24 hrs. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a. m. 19 Month, Day, Year p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) Landover Hills, Md. | | | | 20g. (County) Prince George | | 20h. (State) Md. | |
| 21. I certify that I attended the deceased from 6/7/57 19 56 , to 6/8/57 19 56 , that I last saw the deceased alive on 6/8/57 19 57 , and that death occurred at 9:25 AM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Dr. F. Musser | | | | DATE SIGNED 6/8/57 | | | |
| PHYSICIAN'S NAME (Type) Dr. F. Musser | | | | ADDRESS (Street, city or town, state) 2409 Vassar St. Landover Hills, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation | | 22b. DATE THEREOF 6/9/57 | | 22c. NAME OF CEMETERY OR CREMATORY Greensboro | | 22d. LOCATION (City, town, or county) (State) North Carolina | |
| 23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland. | | | | 24a. REC'D BY REGISTRAR DATE JUN 12 57 | | 24b. REGISTRAR'S SIGNATURE W. Smith | |

RECEIVED

JUN 12 1957

BUREAU V. S.

CERTIFICATE OF DEATH

MARY AND STATE DEPARTMENT OF HEALTH-BALTIMORE 13

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06614

6612

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|--|---|---|--|--|--|
| 1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vest Hyattsville | | c. LENGTH OF STAY IN 1b 12 Days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 23 Greenbelt Md | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3304 Lancer Drive | | | | d. STREET ADDRESS Glendale Rd | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Mary Middle Grace Last Cipriano | | | | 4. DATE OF DEATH June 26, Day 19 Year 57 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 16, 1957 | 9. AGE (In years last birthday) 37 1/2 yrs. | IF UNDER 1 YEAR Months 3 Days 1 Hours 1 Min. | IF UNDER 24 HRS. Months 3 Days 1 Hours 1 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10b. KIND OF BUSINESS OR INDUSTRY none | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME MICHEL CIPRIANO | | | | 14. MOTHER'S MAIDEN NAME Rita E. Taylor | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. --- | | 17. INFORMANT Rita E. Taylor Address Greenbelt, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) VASCULAR COLLAPSE. 751X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) INCREASED INTRACRANIAL PRESSURE DUE TO (c) HYDROCEPHALUS + MENINGOCELE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) LIFE LIFE | | | | | | INTERVAL BETWEEN ONSET AND DEATH 30 MIN. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) --- | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour 9 p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) --- | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 6/22 , 19 57 , to 6/26 , 19 57 , that I last saw the deceased alive on 6/22 , 19 57 , and that death occurred at 11:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) JOSEPH J. MCDONALD, M.D. 7300 RIGGS ROAD UNIVERSITY CITY APTS. W. HYATTSVILLE, MD. DATE SIGNED 6/26/57 | | | | | | | |
| ACTUAL SIGNATURE Joseph J. McDonald MD. | | PHYSICIAN'S NAME (Type) JOSEPH J. MCDONALD, M.D. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/27/57 | | 22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery | | 22d. LOCATION (City, town, or county) (State) Washington D. C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md. | | | | 24a. REC'D BY REGISTRAR JUN 28 1957 | | | |
| | | | | 24b. REGISTRAR'S SIGNATURE James Lewis | | | |

2075284XV4

BUREAU V. S.

JUN 28 1957

RECEIVED

6636

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PRINCE GEORGES</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>16 MT. RAINIER</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PRINCE GEORGES GEN. HOSP.</u> | | d. STREET ADDRESS <u>4117 - 31st. St.</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>BARRY BARRY COSTELLO</u> | | 4. DATE OF DEATH <u>June 28 1957</u> | |
| 5. SEX <u>M.</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 23 1957</u> |
| 9. AGE (In years last birthday) <u>2</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>30</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Cheverly, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>Joseph Louis Costello Sr.</u> | | 14. MOTHER'S MAIDEN NAME <u>Dorothy Tranth</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>Hospital records</u> | |
| 17. INFORMANT <u>Hospital records</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis</u> DUE TO <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u>57</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>6/23, 1957</u> , to <u>6/23, 1957</u> , that I last saw the deceased alive on <u>6/23, 1957</u> , and that death occurred at <u>11:45 P.M.</u> from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) <u>Mt. Rainier</u> DATE SIGNED <u>md.</u> | |
| ACTUAL SIGNATURE <u>Charles C. Hageage</u> | | M.D. <u>md.</u> | |
| PHYSICIAN'S NAME (Type) <u>CHARLES C. HAGEAGE</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>6/25/57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u> | 22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Halley's Funeral Home</u> | | ADDRESS <u>Mt. Rainier, Md.</u> | |
| 24a. REC'D BY REGISTRAR <u>—</u> | | 24b. REGISTRAR'S SIGNATURE <u>—</u> | |
| DATE <u>JUN 27 '57</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 100-100

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. NAME OF DECEASED <i>[Faint text]</i> | | 2. SEX <i>[Faint text]</i> | | 3. AGE <i>[Faint text]</i> | | 4. DATE OF DEATH <i>[Faint text]</i> | |
| 5. PLACE OF BIRTH <i>[Faint text]</i> | | 6. OCCUPATION <i>[Faint text]</i> | | 7. CAUSE OF DEATH <i>[Faint text]</i> | | 8. MANNER OF DEATH <i>[Faint text]</i> | |
| 9. SIGNATURE OF PHYSICIAN <i>[Faint text]</i> | | 10. SIGNATURE OF REGISTRAR <i>[Faint text]</i> | | 11. SIGNATURE OF WITNESS <i>[Faint text]</i> | | 12. SIGNATURE OF DECEASED <i>[Faint text]</i> | |
| 13. SIGNATURE OF FUNERAL HOME <i>[Faint text]</i> | | 14. SIGNATURE OF BURIAL PLACE <i>[Faint text]</i> | | 15. SIGNATURE OF CEMETERY <i>[Faint text]</i> | | 16. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | |
| 17. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 18. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 19. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 20. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | |
| 21. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 22. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 23. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 24. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | |
| 25. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 26. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 27. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 28. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | |
| 29. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 30. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 31. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 32. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | |
| 33. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 34. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 35. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 36. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | |
| 37. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 38. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 39. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 40. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | |
| 41. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 42. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 43. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 44. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | |
| 45. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 46. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 47. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 48. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | |
| 49. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 50. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 51. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 52. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | |
| 53. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 54. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 55. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 56. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | |
| 57. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 58. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 59. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 60. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | |
| 61. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 62. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 63. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 64. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | |
| 65. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 66. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 67. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 68. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | |
| 69. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 70. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 71. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 72. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | |
| 73. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 74. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 75. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 76. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | |
| 77. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 78. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 79. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 80. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | |
| 81. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 82. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 83. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 84. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | |
| 85. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 86. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 87. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 88. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | |
| 89. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 90. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 91. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 92. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | |
| 93. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 94. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 95. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 96. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | |
| 97. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 98. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 99. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | | 100. SIGNATURE OF INTERVIEWER <i>[Faint text]</i> | |

BUREAU V. 5

JUN 27 1957

RECEIVED

6637

CERTIFICATE OF DEATH

06616

Reg. Dist. No.

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b 11 Hrs | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Baby Middle Girl Last Curtis | | 4. DATE OF DEATH Month June Day 2 Year 19 57 | |
| 5. SEX Female | 6. COLOR OF RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1 June 1957 |
| 9. AGE (In years lost birthday) yrs. | | IF UNDER 1 YEAR Months 11 Days 11 Hours 11 Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --- | | 10b. KIND OF BUSINESS OR INDUSTRY --- | 11. BIRTHPLACE (State or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME Frederick Curtis | |
| 14. MOTHER'S MAIDEN NAME Irene Burroughs | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) --- | |
| 16. SOCIAL SECURITY NO. --- | | 17. INFORMANT Frederick Curtis Address Upper Marlboro, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity DUE TO (c) --- | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from June 1, 1957 , to June 2, 1957 , that I last saw the deceased alive on June 2, 1957 , and that death occurred at 7,30 A.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE J. Perkins | | ADDRESS (Street, city or town/state) DATE SIGNED 5301 Hamilton St., Hyattsville, Md. 6/5/57 | |
| PHYSICIAN'S NAME (Type) J. Perkins | | 5301 Hamilton St., Hyattsville, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 6/4/57 | 22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery | 22d. LOCATION (City, town, or county) (State) Upper Marlboro, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. | | ADDRESS Upper Marlboro, Md. | |
| 24a. REC'D BY REGISTRAR JUN 6 '57 | | 24b. REGISTRAR'S SIGNATURE W. Beach | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2077202XVO

JUN 9 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6638

06617

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|--------------------------------------|--|
| 1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> COUNTY <u>Prince Georges</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>John Joseph Dailey</u> | | | | 4. DATE OF DEATH <u>June 7 1957</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Aug 12 1907</u> | |
| 9. AGE (In years last birthday) <u>50</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumbing Inspector</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing</u> | | | |
| 11. BIRTHPLACE (State or foreign country) <u>Columbia S.C.</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>Robert Dailey</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW II</u> | | | | 16. SOCIAL SECURITY NO. <u>589-07-188</u> | | | |
| 17. INFORMANT <u>May Dailey</u> | | | | Address <u>same as #2</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute congestive heart failure</u> DUE TO <u>Cardiovascular renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>434.1</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 22b. DATE THEREOF | | | |
| 22c. NAME OF CEMETERY OR CREMATORY | | | | 22d. LOCATION (City, town, or county) (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Mattingly</u> | | | | 24. REC'D BY REGISTRAR <u> </u> DATE <u>JUN 12 57</u> | | | |
| 24b. REGISTRAR'S SIGNATURE <u> </u> | | | | | | | |

MEDICAL CERTIFICATION

2

99

1

STATE OF NEW YORK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH



ORIGINAL AT
NEW YORK

RECEIVED
JUN 12 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar and to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6639

CERTIFICATE OF DEATH

Reg. Dist. No. 06618

| | | | | | | | |
|--|------------------------|--|---------------------------------|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesapeake</i> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Greenbelt</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George Gen. Hospital | | | | d. STREET ADDRESS 32--E--Crescent Dr. | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First MIDDLE Last RICHARD T. DARMOHRAY Jr. | | 4. DATE OF DEATH Month Day Year June 18th 19 57 | | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 31st-1956 | 9. AGE (In years last birthday) yrs. 10 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Richard T. Darmohray | | | | 14. MOTHER'S MAIDEN NAME Lois H. King | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Richard T. Darmohray- 32-E-Crescent Dr. Greenbelt, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory failure, + Cardiac failure</i> 351X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>715X</i> (b) <i>Central Cerebral palsy + ulcer.</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Trophic peptic ulcer</i> INTERVAL BETWEEN ONSET AND DEATH <i>10 months</i> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>6-17-57</i> to <i>6-18-57</i> , that I last saw the deceased alive on <i>6-18-57</i> , and that death occurred at <i>6:30 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE <i>B. Van Gelderen</i> M.D. | | | | 3001-Cheverly Ave., Cheverly, Md 6-18-57 | | | |
| PHYSICIAN'S NAME (Type) Dr. Bertha Van Gelderen | | | | 3001--Cheverly Ave., Cheverly Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-20-57 | | 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill | | 22d. LOCATION (City, town, or county) (State) Suitland Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Simmons Bros.</i> 1661--Good Hope Rd., SE Washington, DC | | | | 24a. REC'D BY REGISTRAR DATE JUN 20 57 | | 24b. REGISTRAR'S SIGNATURE <i>Paul...</i> | |

5077181XV3

JUN 20 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

6640

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | | c. LENGTH OF STAY IN 1b 15 Days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General | | | | d. STREET ADDRESS 317 73rd St. | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Mattie Middle L Last Drew | | | | 4. DATE OF DEATH Month June Day 15 Year 1957 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 5-17-73 | |
| 9. AGE (In years last birthday) 81 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY own home | |
| 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U S A | | 13. FATHER'S NAME Aaron M Evans | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Frank B Mc Clanahan Carmody Hills Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis CVR Disease DUE TO (c) 10 years | | | | INTERVAL BETWEEN ONSET AND DEATH 3 weeks | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 332X | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 21. I certify that I attended the deceased from May 15, 1957 to June 15, 1957 that I last saw the deceased alive on June 15, 1957 , and that death occurred at 5:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6124 Central Ave Capital Bldg Md DATE SIGNED 6/15/57 | | | |
| ACTUAL SIGNATURE William Brainin | | | | PHYSICIAN'S NAME (Type) WM BRAININ | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/18/57 | | 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemtery | | 22d. LOCATION (City, town, or county) (State) Suitland Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. Bascherson | | | | ADDRESS Hyattsville, Md | | 24a. REC'D BY REGISTRAR DATE JUN 19 57 | |
| 24b. REGISTRAR'S SIGNATURE Rehman | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 10-54-10

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. NAME OF DECEASED <i>JOHN J. SMITH</i> | | 2. SEX <i>Male</i> | | 3. AGE <i>45</i> | | 4. RACE <i>White</i> | |
| 5. PLACE OF BIRTH <i>New York City, N.Y.</i> | | 6. DATE OF BIRTH <i>Jan 15, 1912</i> | | 7. PLACE OF DEATH <i>Baltimore, Md.</i> | | 8. DATE OF DEATH <i>June 10, 1957</i> | |
| 9. CAUSE OF DEATH <i>Myocardial Infarction</i> | | 10. PLACE OF INTERMENT <i>St. Mary's Cemetery</i> | | 11. NAME OF FUNERAL HOME <i>St. Mary's Funeral Home</i> | | 12. SIGNATURE OF DECEASED <i>John J. Smith</i> | |
| 13. SIGNATURE OF WITNESS <i>John J. Smith</i> | | 14. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 15. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 16. SIGNATURE OF DECEASED <i>John J. Smith</i> | |
| 17. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 18. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 19. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 20. SIGNATURE OF DECEASED <i>John J. Smith</i> | |
| 21. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 22. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 23. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 24. SIGNATURE OF DECEASED <i>John J. Smith</i> | |
| 25. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 26. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 27. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 28. SIGNATURE OF DECEASED <i>John J. Smith</i> | |
| 29. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 30. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 31. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 32. SIGNATURE OF DECEASED <i>John J. Smith</i> | |
| 33. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 34. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 35. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 36. SIGNATURE OF DECEASED <i>John J. Smith</i> | |
| 37. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 38. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 39. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 40. SIGNATURE OF DECEASED <i>John J. Smith</i> | |
| 41. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 42. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 43. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 44. SIGNATURE OF DECEASED <i>John J. Smith</i> | |
| 45. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 46. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 47. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 48. SIGNATURE OF DECEASED <i>John J. Smith</i> | |
| 49. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 50. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 51. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 52. SIGNATURE OF DECEASED <i>John J. Smith</i> | |
| 53. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 54. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 55. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 56. SIGNATURE OF DECEASED <i>John J. Smith</i> | |
| 57. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 58. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 59. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 60. SIGNATURE OF DECEASED <i>John J. Smith</i> | |
| 61. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 62. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 63. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 64. SIGNATURE OF DECEASED <i>John J. Smith</i> | |
| 65. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 66. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 67. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 68. SIGNATURE OF DECEASED <i>John J. Smith</i> | |
| 69. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 70. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 71. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 72. SIGNATURE OF DECEASED <i>John J. Smith</i> | |
| 73. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 74. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 75. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 76. SIGNATURE OF DECEASED <i>John J. Smith</i> | |
| 77. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 78. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 79. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 80. SIGNATURE OF DECEASED <i>John J. Smith</i> | |
| 81. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 82. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 83. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 84. SIGNATURE OF DECEASED <i>John J. Smith</i> | |
| 85. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 86. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 87. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 88. SIGNATURE OF DECEASED <i>John J. Smith</i> | |
| 89. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 90. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 91. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 92. SIGNATURE OF DECEASED <i>John J. Smith</i> | |
| 93. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 94. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 95. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 96. SIGNATURE OF DECEASED <i>John J. Smith</i> | |
| 97. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 98. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 99. SIGNATURE OF DECEASED <i>John J. Smith</i> | | 100. SIGNATURE OF DECEASED <i>John J. Smith</i> | |

BUREAU A. E.

JUN 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6641

CERTIFICATE OF DEATH

06620

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Prince George MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY Pg. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md | | | | c. LENGTH OF STAY IN 1b 2 Days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 36 Capital Hgts. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hosp. | | | | d. STREET ADDRESS 616- 59th Ave. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First William Middle Henry Last Durity | | | | 4. DATE OF DEATH Month June Day 27 Year 19 57 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH July 6, 1873 | |
| 9. AGE (In years last birthday) 83 yrs. | | IF UNDER 1 YEAR Months 27 Days 27 Hours 19 Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plaster | | 10b. KIND OF BUSINESS OR INDUSTRY Building | | 11. BIRTHPLACE (State or foreign country) Beltsville, Md. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Unknown | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Mr. Abigail Arnold | | Address Route 2 Box 644 Springfield, Va. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho genic carcinoma left 162x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) carcinomatous DUE TO (c) | | | | INTERVAL BETWEEN ONSET AND DEATH 5 mos. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 6/24 , 19 57 , to 6/27 , 19 57 , that I last saw the deceased alive on 6/27 , 19 57 , and that death occurred at 1:20 AM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE William Durity Comeau | | | | ADDRESS (Street, city or town, state) 3503 Cherry St | | DATE SIGNED 6/27/57 | |
| PHYSICIAN'S NAME (Type) Dr. Comeau | | | | MT Comeau md | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF July 1, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY Washington National | | 22d. LOCATION (City, town, or county) (State) Suitland, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W W Chamber | | | | ADDRESS 517 11th St SE | | 24a. REC'D BY REGISTRAR DATE JUL 1 57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Overland | | | |

6642

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|------------------------------|---|---|--|---|--|------------------|
| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY PRINCE GEORGES | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGES GEN. HOSP. | | | | d. STREET ADDRESS 7722 EMERSON RD. | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last RICHARD O. ELAM | | | | 4. DATE OF DEATH Month Day Year JUNE 1 1957 | | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb 18, 1919 | | 9. AGE (In years lost birthday) yrs. 38 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boiler operator | | 10b. KIND OF BUSINESS OR INDUSTRY Power Company | | 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME William J. Elam | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) W W 11 | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Patricia Elam W Lanham Hills Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Hemorrhagic Pancreatitis 587.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 1, 1957 to June 1, 1957 , that I last saw the deceased alive on June 1, 1957 , and that death occurred at 9:00AM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Frederick E. Musser M.D. | | | | ADDRESS (Street, city or town, state) DATE SIGNED 28090 Arming St 6/1/57 Landon Hills Md. | | | |
| PHYSICIAN'S NAME (Type) FREDERICK MUSSER | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/4/57 | | 22c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery | | 22d. LOCATION (City, town, or county) (State) Arlington Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md. | | | | 24a. RECEIVED BY REGISTRAR DATE | | 24b. REGISTRAR'S SIGNATURE Rob. French | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 5 1957

BUREAU V. 2

June 1

2:00

June 1

June 1

7

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JUN 1

38

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for use in burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6643

CERTIFICATE OF DEATH

06622

Reg. Dist. No.

| | | | |
|--|------------------------|---|-----------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier, Md 16 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Prince Georges General Hospital | | d. STREET ADDRESS 4234-34th Street 1 | |
| 3. NAME OF DECEASED (Type or print) William J. Erhart | | 4. DATE OF DEATH Month 6-13th Day 1957 Year | |
| 5. SEX Male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct 1-1879 |
| 9. AGE (In years last birthday) 77 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Sheet metal worker, sheet metal | | 10b. KIND OF BUSINESS OR INDUSTRY sheet metal | |
| 11. BIRTHPLACE (State or foreign country) Auburn, N. Y. | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME George Erhart | | 14. MOTHER'S MAIDEN NAME Catherine Haha | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 216-22-0716 | |
| 17. INFORMANT Mrs. Dorothy Carr | | Address 4234-34th Mt. Rainier, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 PULMONARY INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-sclerotic Heart Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 days 3 yrs. | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 465X | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from JUNE 7th, 1957, to JUNE 13th, 1957, that I last saw the deceased alive on JUNE 13th, 1957, and that death occurred at 3:05 PM, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE C. C. Hageage | | ADDRESS (Street, city or town, state) 3308 Perry St., Mt. Rainier, Md. | |
| PHYSICIAN'S NAME (Type) C. C. Hageage M.D. | | DATE SIGNED 6/13/57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/15/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln | | 22d. LOCATION (City, town, or county) (State) Colmar Manor, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Valley's Funeral Home | | ADDRESS Mt. Rainier, Md. | |
| 24a. REC'D BY REGISTRAR DATE JUN 17 '57 | | 24b. REGISTRAR'S SIGNATURE | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | |
|------------------------|--|------|--|-----------|--|-----------|--|---------------|--|----------------|--|-----------|--|-----------|--|-----------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY | | COUNTY | | STATE | |
| JAMES EARL RAY | | 35 | | M | | W | | 1922 | | MOBILE | | ALABAMA | | ALABAMA | | ALABAMA | |
| MARRIAGE | | DATE | | PLACE | | CITY | | COUNTY | | STATE | | CITY | | COUNTY | | STATE | |
| MARRIED | | 1948 | | MOBILE | | ALABAMA | | ALABAMA | | ALABAMA | | ALABAMA | | ALABAMA | | ALABAMA | |
| OCCUPATION | | DATE | | PLACE | | CITY | | COUNTY | | STATE | | CITY | | COUNTY | | STATE | |
| ATTORNEY | | 1948 | | MOBILE | | ALABAMA | | ALABAMA | | ALABAMA | | ALABAMA | | ALABAMA | | ALABAMA | |
| CAUSE OF DEATH | | DATE | | PLACE | | CITY | | COUNTY | | STATE | | CITY | | COUNTY | | STATE | |
| HEART DISEASE | | 1957 | | MOBILE | | ALABAMA | | ALABAMA | | ALABAMA | | ALABAMA | | ALABAMA | | ALABAMA | |
| MANNER OF DEATH | | DATE | | PLACE | | CITY | | COUNTY | | STATE | | CITY | | COUNTY | | STATE | |
| NATURAL | | 1957 | | MOBILE | | ALABAMA | | ALABAMA | | ALABAMA | | ALABAMA | | ALABAMA | | ALABAMA | |
| PLACE OF DEATH | | DATE | | PLACE | | CITY | | COUNTY | | STATE | | CITY | | COUNTY | | STATE | |
| BALTIMORE | | 1957 | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | |
| SIGNATURE OF PHYSICIAN | | DATE | | PLACE | | CITY | | COUNTY | | STATE | | CITY | | COUNTY | | STATE | |
| JAMES EARL RAY | | 1957 | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | |
| SIGNATURE OF REGISTRAR | | DATE | | PLACE | | CITY | | COUNTY | | STATE | | CITY | | COUNTY | | STATE | |
| JAMES EARL RAY | | 1957 | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | |

BUREAU V. S.

JUN 17 1957

RECEIVED

6644

CERTIFICATE OF DEATH

06623

Reg. Dist. No.

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 25 Riverdale | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Prince Georges Gen. Hosp. | | d. STREET ADDRESS 5308 Taylor Rd. | |
| 3. NAME OF DECEASED (Type or print) Clyde H. Flack | | 4. DATE OF DEATH June 4 1957 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5-26-17 |
| 9. AGE (In years last birthday) 39 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cat operator | | 10b. KIND OF BUSINESS OR INDUSTRY self | |
| 11. BIRTHPLACE (State or foreign country) Ohio | | 12. CITIZEN OF WHAT COUNTRY? U.S.A | |
| 13. FATHER'S NAME Charles H. Flack | | 14. MOTHER'S MAIDEN NAME Virginia Van Meter | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service | | 16. SOCIAL SECURITY NO. — | |
| 17. INFORMANT Mary E. Flack | | Address Riverdale Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ruptured aortic aneurysm 451x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic heart disease DUE TO (c) 20 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 416x INTERVAL BETWEEN ONSET AND DEATH 5 minutes | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from July 20, 1955, to June 4, 1957, that I last saw the deceased alive on June 4, 1957, and that death occurred at 8:15 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Leonard Lintsky | | ADDRESS (Street, city or town, state) 4300 Keywood Dr. DATE SIGNED 6/4/57 | |
| PHYSICIAN'S NAME (Type) M. Rainier, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 6/7/57 | 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill | 22d. LOCATION (City, town, or county) (State) Suitland Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Franka Sons | | ADDRESS Hyattsville Md. | |
| 24a. REC'D BY REGISTRAR DATE JUN 10 '57 | | 24b. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6645

CERTIFICATE OF DEATH

06624

Reg. Dist. No.

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington D.C. 47X-3 | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D.C. 47X-3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's Hospital | | d. STREET ADDRESS 4311 13th Street, N.E. | |
| 3. NAME OF DECEASED (Type or print) James William Franks | | 4. DATE OF DEATH Month June Day 28 Year 19 57 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 9, 1872 |
| 9. AGE (In years last birthday) 85 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Railroad-Illinois Virginia | |
| 11. BIRTHPLACE (State or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Charles F. Franks | | 14. MOTHER'S MAIDEN NAME Margaret S. Nalls | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Mrs. Ruby Montgomery-4311 13th St., N.E. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C. V. A. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic disease DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 6-1-57 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 6-18 , 19 57 to 6-28 , 19 57 , that I last saw the deceased alive on 6-28 , 19 57 , and that death occurred at 9:48 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cottage City, Md. DATE SIGNED 6/28/57 | | | |
| ACTUAL SIGNATURE George J. Hageage M.D. 3717-38th St. | | DATE SIGNED 6/28/57 | |
| PHYSICIAN'S NAME (Type) George J. Hageage | | Cottage City, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 7/1/1957 | |
| 22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery | | 22d. LOCATION (City, town, or county) (State) Prince Georges County, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.-2901 14th St., N.W. | | 24a. RECEIVED BY REGISTRAR DATE | |
| 24b. REGISTRAR'S SIGNATURE W. H. Hines | | DATE | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | |
|------------------------|--|----------------------|--|----------------------|--|----------------------|--|----------------------|--|----------------------|--|------------------------|--|----------------------|--|----------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY OF BIRTH | | STATE OF BIRTH | | COUNTRY OF BIRTH | |
| JAMES H. HARRIS | | 65 | | M | | W | | 1892 | | BALTIMORE | | BALTIMORE | | MARYLAND | | UNITED STATES | |
| OCCUPATION | | EDUCATION | | MARRIAGE | | RELIGION | | DATE OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | | STATE OF DEATH | | COUNTRY OF DEATH | |
| LABORER | | 8 | | M | | C | | JUL 1 1957 | | BALTIMORE | | BALTIMORE | | MARYLAND | | UNITED STATES | |
| CAUSE OF DEATH | | MANNER OF DEATH | | DATE OF EXAMINATION | | PLACE OF EXAMINATION | | CITY OF EXAMINATION | | STATE OF EXAMINATION | | COUNTRY OF EXAMINATION | | DATE OF INTERMENT | | PLACE OF INTERMENT | |
| HEART DISEASE | | NATURAL | | JUL 1 1957 | | BALTIMORE | | BALTIMORE | | MARYLAND | | UNITED STATES | | JUL 1 1957 | | BALTIMORE | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF CORONER | | SIGNATURE OF WITNESS | | SIGNATURE OF WITNESS | | SIGNATURE OF WITNESS | | SIGNATURE OF WITNESS | | SIGNATURE OF WITNESS | | SIGNATURE OF WITNESS | | SIGNATURE OF WITNESS | |
| JAMES H. HARRIS | | JAMES H. HARRIS | | JAMES H. HARRIS | | JAMES H. HARRIS | | JAMES H. HARRIS | | JAMES H. HARRIS | | JAMES H. HARRIS | | JAMES H. HARRIS | | JAMES H. HARRIS | |

BUREAU V. 3

JUL 1 1957

RECEIVED

6646

06625

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | |
|---|----------------------------------|---|--|--|---|
| 1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md. | | c. LENGTH OF STAY IN 1b 2 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 33 Bladensburg, Md. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's Hospital | | | d. STREET ADDRESS 4203 53rd Avenue,. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) Roy Francis Frohlich | | | 4. DATE OF DEATH June 1, 19 57. | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 20, 1912 | | 9. AGE (In years lost birthday) yrs. 45 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Fireman | | 10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt. | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME John H. Frohlich | | | 14. MOTHER'S MAIDEN NAME Sadie J. Owens | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. ? | | 17. INFORMANT Lucy Frohlich Address Same as # 2 (Wife) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary infarction 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) chronic emphysema DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1 | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 day 2 yrs. |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. g. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 5/27 , 19 57 , to 6-1 , 19 57 , that I last saw the deceased alive on 6-1 , 19 57 , and that death occurred at 3 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3717-38th Ave DATE SIGNED 6-1-57 | | | | | |
| ACTUAL SIGNATURE George Hageage | | M.D. 3717-38th Ave | | DATE SIGNED 6-1-57 | |
| PHYSICIAN'S NAME (Type) George Hageage | | 3717 38th Ave Cottage City, Md | | | |
| 22a. BURIAL, CREMATION, REMOVAL (specify) Burial | | 22b. DATE THEREOF 6/4/57 | | 22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery | |
| | | | | 22d. LOCATION (City, town, or county) (State) Colmar Manor, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons | | | ADDRESS Hyattsville, Maryland. | | |
| 24a. REC'D BY REGISTRAR DATE JUN 6 57 | | 24b. REGISTRAR'S SIGNATURE W. Hedrick | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

| | | | | | | | |
|------------------------|--|------------------------|--|----------------------|--|-------------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | |
| JOHN J. FROST | | MALE | | 65 | | JAN 1 1892 | |
| RESIDENCE | | OCCUPATION | | CAUSE OF DEATH | | MANNER OF DEATH | |
| 1234 5th Avenue | | Retired | | Heart Disease | | Natural | |
| DATE OF DEATH | | PLACE OF DEATH | | CERTIFICATE NO. | | REGISTRATION NO. | |
| JUN 6 1957 | | HOME | | 1234 | | 5678 | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF REGISTRAR | | DATE OF REGISTRATION | | PLACE OF REGISTRATION | |
| [Signature] | | [Signature] | | JUN 6 1957 | | BUREAU OF VITAL RECORDS | |

BUREAU V. S.

JUN 6 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | 06626 |
|---|--|--|--|--|---|--|--|--|--|----------------|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | Reg. Dist. No. |
| 1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>District of Columbia</u> COUNTY <u>Washington</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-9 | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u> | | | | | d. STREET ADDRESS <u>4630 New Hampshire</u> | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Robert Anthony Goss</u> | | | | | 4. DATE OF DEATH <u>June 12 1957</u> | | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Oct 8, 1904</u> | | 9. AGE (In years last birthday) <u>52</u> yrs. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Personnel</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u> | | 11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u> | | IF UNDER 1 YEAR IF UNDER 24 MRS. Months Days Hours Min. | | |
| 13. FATHER'S NAME <u>William Goss</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Catherine Lauer</u> | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>No</u> | | | | | 16. SOCIAL SECURITY NO. <u>44-08-10000</u> | | | | | |
| 17. INFORMANT <u>Charles E. Goss</u> | | | | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cardiovascular renal disease</u> (c), stating the underlying cause last. <u>Cardiovascular renal disease</u> | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>442X</u> | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | | Month, Day, Year 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | | | | 22b. DATE THEREOF <u>6-10-57</u> | | | | | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u> | | | | | 22d. LOCATION (City, town, or county) (State) <u>WASH. D.C.</u> | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Hendon</u> | | | | | 24a. REC'D BY REGISTRAR <u>JUN 17 57</u> | | | | | |
| ADDRESS <u>3831-GA-Ave. N.W.</u> | | | | | 24b. REGISTRAR'S SIGNATURE <u>W. Leach</u> | | | | | |

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUN 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6611

CERTIFICATE OF DEATH

06627

Reg. Dist. No.

230

| | | | | | | | |
|---|----------------------------------|---|---|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>College Park Md</i> | | c. LENGTH OF STAY IN 1b <i>2 years</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>14 College Park, Md</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>5113 Kenesaw St</i> | | | | d. STREET ADDRESS <i>1 5113 Kenesaw St</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <i>BLANCHE</i> Middle <i>B.</i> Last <i>GOODWIN</i> | | | | 4. DATE OF DEATH Month <i>June</i> Day <i>23</i> Year <i>1957</i> | | | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Jan 29, 1886</i> | 9. AGE (In years last birthday) <i>69</i> yrs. | IF UNDER 1 YEAR Months <i>5</i> Days <i>1</i> Hours <i>1</i> Min. | IF UNDER 24 HRS. Months <i>5</i> Days <i>1</i> Hours <i>1</i> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i> | | 11. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i> | |
| 13. FATHER'S NAME <i>Wm E. Clark</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Bertha Burke</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> | | 16. SOCIAL SECURITY NO. <i>none</i> | | 17. INFORMANT <i>Jacqueline R. Petro</i> Address <i>College Park Md.</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (b), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of</i> <i>153X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>according to</i> DUE TO <i>abdominal metastasis</i> (c) <i>metastasis</i> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>5 months</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>19</i> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) <i>Washington D.C.</i> | | (County) (State) | |
| 21. I certify that I attended the deceased from <i>Nov 1</i> 19 <i>56</i> to <i>June 24</i> 19 <i>57</i> , that I last saw the deceased alive on <i>June 23</i> 19 <i>57</i> , and that death occurred at <i>10</i> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <i>J. Chester Brady</i> M.D. | | | | ADDRESS (Street, city or town, state) <i>35 N Y ave N W Washington D. C.</i> | | | |
| PHYSICIAN'S NAME (Type) <i>J. Chester Brady</i> | | | | DATE SIGNED <i>June 28 1957</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>6/27/57</i> | | 22c. NAME OF CEMETERY OR CREMATORY <i>Arlington National</i> | | 22d. LOCATION (City, town, or county) (State) <i>Arlington Va</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>F Gasche sons Hyattsville Md</i> | | | | 24a. REC'D BY REGISTRAR <i>JUN 28 1957</i> | | | |
| | | | | 24b. REGISTRAR'S SIGNATURE <i>John Smith</i> | | | |

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | | | | | | | |
|------------------------|--|-----------------------|--|-----------------------|--|----------------------|--|--------------------|--|--------------------------|--|----------------------|--|--------------------|--|-----------------------|--|--------------------------|--|----------------------------|--|----------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. DATE OF BIRTH | | 5. PLACE OF BIRTH | | 6. OCCUPATION | | 7. CAUSE OF DEATH | | 8. MANNER OF DEATH | | 9. PLACE OF DEATH | | 10. TIME OF DEATH | | 11. SIGNATURE OF PHYSICIAN | | 12. SIGNATURE OF REGISTRAR | |
| JAMES J. JAMES | | M | | 45 | | JAN 1 1912 | | BOSTON, MASS. | | LABORER | | HEART DISEASE | | NATURAL | | HOSPITAL | | 10:30 AM | | J. J. JAMES | | J. J. JAMES | |
| 13. PLACE OF INTERMENT | | 14. NAME OF INTERMENT | | 15. DATE OF INTERMENT | | 16. NAME OF MINISTER | | 17. NAME OF CHURCH | | 18. NAME OF FUNERAL HOME | | 19. NAME OF CEMETERY | | 20. NAME OF BURIAL | | 21. NAME OF CREMATION | | 22. NAME OF INCINERATION | | 23. NAME OF URN | | 24. NAME OF CASK | |
| ST. MARY'S CHURCH | | ST. MARY'S CHURCH | | JUN 28 1957 | | J. J. JAMES | | ST. MARY'S CHURCH | | J. J. JAMES | | ST. MARY'S CHURCH | | ST. MARY'S CHURCH | | ST. MARY'S CHURCH | | ST. MARY'S CHURCH | | ST. MARY'S CHURCH | | ST. MARY'S CHURCH | |

RECEIVED
JUN 28 1957
BUREAU V. 2

6693

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|-------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>District of Columbia</u> b. COUNTY <u>13</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Glenn Dale Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN E. GREEN</u> | | DATE OF DEATH Month Day Year <u>JUNE 30, 1957</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Colored</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12/29/15</u> |
| 9. AGE (In years last birthday) <u>41</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u> | |
| 11. BIRTH PLACE (State or foreign country) <u>Washington, D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>David Green</u> | | 14. MOTHER'S MAIDEN NAME <u>Elinor Thomas</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>578-12-9155</u> | |
| 17. INFORMANT <u>Deceased</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchiogenic Carcinoma left lung</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Tuberculosis</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from <u>8/4/1955</u> to <u>6/30/1957</u> , that I last saw the deceased alive on <u>6/30/1957</u> , and that death occurred at <u>5:35 A.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>MOE WEISS</u> | | DATE SIGNED <u>GLENN DALE HOSPITAL</u> | |
| PHYSICIAN'S NAME (Type) <u>MOE WEISS M.D.</u> | | <u>GLENN DALE, MARYLAND</u> | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) <u>REMOVAL</u> | 22b. DATE THEREOF <u>6/30/57</u> | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Engene Campbell</u> | | ADDRESS <u>4339 Hunt Pl. N.E.</u> | 24a. REC'D BY REGISTRAR <u>DATE 2-57</u> |
| 24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|--|--|--|--|--|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | |
| 4. PLACE OF BIRTH | | 5. DATE OF BIRTH | | 6. DATE OF DEATH | |
| 7. PLACE OF DEATH | | 8. CAUSE OF DEATH | | 9. MANNER OF DEATH | |
| 10. SIGNATURE OF PHYSICIAN | | 11. SIGNATURE OF REGISTRAR | | 12. SIGNATURE OF WITNESSES | |
| 13. SIGNATURE OF DECEASED | | 14. SIGNATURE OF NEXT OF KIN | | 15. SIGNATURE OF BURIAL OFFICIAL | |
| 16. SIGNATURE OF FUNERAL HOME | | 17. SIGNATURE OF CHURCH | | 18. SIGNATURE OF CEMETERY | |
| 19. SIGNATURE OF HEALTH DEPARTMENT | | 20. SIGNATURE OF COUNTY CLERK | | 21. SIGNATURE OF CITY CLERK | |
| 22. SIGNATURE OF STATE CLERK | | 23. SIGNATURE OF FEDERAL CLERK | | 24. SIGNATURE OF POSTAL CLERK | |
| 25. SIGNATURE OF MARINE CLERK | | 26. SIGNATURE OF AIR FORCE CLERK | | 27. SIGNATURE OF NAVY CLERK | |
| 28. SIGNATURE OF ARMY CLERK | | 29. SIGNATURE OF COAST GUARD CLERK | | 30. SIGNATURE OF CUSTOMS CLERK | |
| 31. SIGNATURE OF INSURANCE CLERK | | 32. SIGNATURE OF BANK CLERK | | 33. SIGNATURE OF POST OFFICE CLERK | |
| 34. SIGNATURE OF RAILROAD CLERK | | 35. SIGNATURE OF TELEPHONE CLERK | | 36. SIGNATURE OF WATER SUPPLY CLERK | |
| 37. SIGNATURE OF GAS COMPANY CLERK | | 38. SIGNATURE OF ELECTRIC COMPANY CLERK | | 39. SIGNATURE OF SANITATION CLERK | |
| 40. SIGNATURE OF FIRE DEPARTMENT CLERK | | 41. SIGNATURE OF POLICE DEPARTMENT CLERK | | 42. SIGNATURE OF JAIL CLERK | |
| 43. SIGNATURE OF COURT CLERK | | 44. SIGNATURE OF PRISON CLERK | | 45. SIGNATURE OF MENTAL HOSPITAL CLERK | |
| 46. SIGNATURE OF ALCOHOLISM CLERK | | 47. SIGNATURE OF DRUGS CLERK | | 48. SIGNATURE OF NARCOTICS CLERK | |
| 49. SIGNATURE OF TOBACCO CLERK | | 50. SIGNATURE OF SUGAR CLERK | | 51. SIGNATURE OF COTTON CLERK | |
| 52. SIGNATURE OF WHEAT CLERK | | 53. SIGNATURE OF RICE CLERK | | 54. SIGNATURE OF CORN CLERK | |
| 55. SIGNATURE OF SOYBEANS CLERK | | 56. SIGNATURE OF PEAS CLERK | | 57. SIGNATURE OF BEANS CLERK | |
| 58. SIGNATURE OF LENTILS CLERK | | 59. SIGNATURE OF PULSES CLERK | | 60. SIGNATURE OF OTHER CEREALS CLERK | |
| 61. SIGNATURE OF OTHER FOODS CLERK | | 62. SIGNATURE OF OTHER BEVERAGES CLERK | | 63. SIGNATURE OF OTHER PRODUCTS CLERK | |
| 64. SIGNATURE OF OTHER SERVICES CLERK | | 65. SIGNATURE OF OTHER INDUSTRIES CLERK | | 66. SIGNATURE OF OTHER TRADES CLERK | |
| 67. SIGNATURE OF OTHER OCCUPATIONS CLERK | | 68. SIGNATURE OF OTHER RESIDENCES CLERK | | 69. SIGNATURE OF OTHER VEHICLES CLERK | |
| 70. SIGNATURE OF OTHER TOOLS CLERK | | 71. SIGNATURE OF OTHER MACHINERY CLERK | | 72. SIGNATURE OF OTHER EQUIPMENT CLERK | |
| 73. SIGNATURE OF OTHER SUPPLIES CLERK | | 74. SIGNATURE OF OTHER MATERIALS CLERK | | 75. SIGNATURE OF OTHER FINISHES CLERK | |
| 76. SIGNATURE OF OTHER PAINTS CLERK | | 77. SIGNATURE OF OTHER GLASSES CLERK | | 78. SIGNATURE OF OTHER METALS CLERK | |
| 79. SIGNATURE OF OTHER WOODS CLERK | | 80. SIGNATURE OF OTHER STONES CLERK | | 81. SIGNATURE OF OTHER CERAMICS CLERK | |
| 82. SIGNATURE OF OTHER TEXTILES CLERK | | 83. SIGNATURE OF OTHER LEATHERS CLERK | | 84. SIGNATURE OF OTHER RUBBERS CLERK | |
| 85. SIGNATURE OF OTHER PLASTICS CLERK | | 86. SIGNATURE OF OTHER GLASSES CLERK | | 87. SIGNATURE OF OTHER METALS CLERK | |
| 88. SIGNATURE OF OTHER WOODS CLERK | | 89. SIGNATURE OF OTHER STONES CLERK | | 90. SIGNATURE OF OTHER CERAMICS CLERK | |
| 91. SIGNATURE OF OTHER TEXTILES CLERK | | 92. SIGNATURE OF OTHER LEATHERS CLERK | | 93. SIGNATURE OF OTHER RUBBERS CLERK | |
| 94. SIGNATURE OF OTHER PLASTICS CLERK | | 95. SIGNATURE OF OTHER GLASSES CLERK | | 96. SIGNATURE OF OTHER METALS CLERK | |
| 97. SIGNATURE OF OTHER WOODS CLERK | | 98. SIGNATURE OF OTHER STONES CLERK | | 99. SIGNATURE OF OTHER CERAMICS CLERK | |
| 100. SIGNATURE OF OTHER TEXTILES CLERK | | 101. SIGNATURE OF OTHER LEATHERS CLERK | | 102. SIGNATURE OF OTHER RUBBERS CLERK | |

BUREAU V. 1

JUL 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar's name, date of burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06629

6694

CERTIFICATE OF DEATH

Reg. Dist. No.

243

| | | | |
|--|------------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Prince George</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural (Bowie)</u> | | c. LENGTH OF STAY IN 1b <u>67yr</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural (Bowie)</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Ruth</u> First <u>Isabelle</u> Middle <u>Greenfield</u> Last | | 4. DATE OF DEATH <u>June</u> Month <u>15</u> Day <u>1957</u> Year | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 14, 1890</u> yrs. <u>67</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (Sole or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Gabriel Fletcher</u> | | 14. MOTHER'S MAIDEN NAME <u>Virginia Randall</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>220-10-5988</u> | |
| 17. INFORMANT <u>Henry Greenfield</u> Address <u>Bowie, Md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Gen. Arteriosclerosis</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>1 yr</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Supracondylar left leg amputation</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>450.1</u> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. j. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>55</u> , to <u>June</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 14</u> , 19 <u>57</u> , and that death occurred at <u>3:45 P.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>D. Henry A. Wise Jr.</u> M.D. | | ADDRESS (Street, city or town, state) <u>Bowie, Md</u> | |
| PHYSICIAN'S NAME (Type) <u>Henry A. Wise, Jr.</u> | | DATE SIGNED | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>6-18-1957</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Church Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Bowie Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Rhines & Co.</u> ADDRESS <u>901 3rd St., S. W.</u> | | 24a. REC'D BY REGISTRAR <u>JUN 18 1957</u> | 24b. REGISTRAR'S SIGNATURE <u>Agnes Youngling</u> |

BUREAU A.

RECEIVED

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for use in burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6695

CERTIFICATE OF DEATH

06630

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn Md | | | | c. LENGTH OF STAY IN lb 8 1/2 years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4812 71th ave | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First John Middle Rufus Last Griffiths Sr | | | | 4. DATE OF DEATH Month June Day 10 Year 1957 | | | |
| 5. SEX male | | 6. COLOR OR RACE white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Oct 25, 1871 | |
| 9. AGE (In years last birthday) 85 years | | IF UNDER 1 YEAR Months 8 Days 10 Hours 19 Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Real Estate Broker Self | | 10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania | |
| 11. BIRTHPLACE (State or foreign country) U S A | | | | 12. CITIZEN OF WHAT COUNTRY? U S A | | | |
| 13. FATHER'S NAME William G. Griffiths | | | | 14. MOTHER'S MAIDEN NAME Emma Malloy | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none | | 17. INFORMANT Helen G. Griffiths Woodlawn, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) 10 years | | | | | | INTERVAL BETWEEN ONSET AND DEATH 8 hours | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) Pittsburg, Pa. | | | | 20g. (County) Pittsburg, Pa. | | 20h. (State) Pittsburg, Pa. | |
| 21. I certify that I attended the deceased from Jan , 19 55 , to June , 19 57 , that I last saw the deceased alive on 10 Jun , 19 57 , and that death occurred at 9:45 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Thomas G. Maloney M.D. | | | | ADDRESS (Street, city or town, state) 4814-71st Ave. Landover Hills Md | | | |
| PHYSICIAN'S NAME (Type) THOMAS G. MALONEY | | | | DATE SIGNED JUN 14 57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/13/57 | | 22c. NAME OF CEMETERY OR CREMATORY Uniondale Cemetery | | 22d. LOCATION (City, town, or county) (State) Pittsburg, Pa. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE F. GASCH'S SONS | | | | ADDRESS Hyattsville, Md. | | 24a. REC'D BY REGISTRAR JUN 14 57 | |
| 24b. REGISTRAR'S SIGNATURE W. H. Leach | | | | | | | |

CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|------------------------------|--|--------------------------------|--|---------------------------------------|--|
| 1. NAME OF DECEASED JAMES EARL RAY | | 2. SEX Male | | 3. AGE 35 | | 4. DATE OF DEATH JUN 6 1968 | |
| 5. PLACE OF DEATH BALTIMORE, MARYLAND | | 6. CAUSE OF DEATH Suicide | | 7. MANNER OF DEATH Homicide | | 8. MEDICAL EXAMINER JAMES EARL RAY | |
| 9. PLACE OF BIRTH MOBILE, ALABAMA | | 10. OCCUPATION None | | 11. MARITAL STATUS Single | | 12. EDUCATION High School | |
| 13. PREVIOUS ILLNESS None | | 14. PREVIOUS SURGERY None | | 15. PREVIOUS TRAUMA None | | 16. PREVIOUS DRUGS None | |
| 17. PREVIOUS ALCOHOL None | | 18. PREVIOUS TOBACCO None | | 19. PREVIOUS OTHER None | | 20. PREVIOUS OTHER None | |
| 21. PREVIOUS OTHER None | | 22. PREVIOUS OTHER None | | 23. PREVIOUS OTHER None | | 24. PREVIOUS OTHER None | |
| 25. PREVIOUS OTHER None | | 26. PREVIOUS OTHER None | | 27. PREVIOUS OTHER None | | 28. PREVIOUS OTHER None | |
| 29. PREVIOUS OTHER None | | 30. PREVIOUS OTHER None | | 31. PREVIOUS OTHER None | | 32. PREVIOUS OTHER None | |
| 33. PREVIOUS OTHER None | | 34. PREVIOUS OTHER None | | 35. PREVIOUS OTHER None | | 36. PREVIOUS OTHER None | |
| 37. PREVIOUS OTHER None | | 38. PREVIOUS OTHER None | | 39. PREVIOUS OTHER None | | 40. PREVIOUS OTHER None | |
| 41. PREVIOUS OTHER None | | 42. PREVIOUS OTHER None | | 43. PREVIOUS OTHER None | | 44. PREVIOUS OTHER None | |
| 45. PREVIOUS OTHER None | | 46. PREVIOUS OTHER None | | 47. PREVIOUS OTHER None | | 48. PREVIOUS OTHER None | |
| 49. PREVIOUS OTHER None | | 50. PREVIOUS OTHER None | | 51. PREVIOUS OTHER None | | 52. PREVIOUS OTHER None | |
| 53. PREVIOUS OTHER None | | 54. PREVIOUS OTHER None | | 55. PREVIOUS OTHER None | | 56. PREVIOUS OTHER None | |
| 57. PREVIOUS OTHER None | | 58. PREVIOUS OTHER None | | 59. PREVIOUS OTHER None | | 60. PREVIOUS OTHER None | |
| 61. PREVIOUS OTHER None | | 62. PREVIOUS OTHER None | | 63. PREVIOUS OTHER None | | 64. PREVIOUS OTHER None | |
| 65. PREVIOUS OTHER None | | 66. PREVIOUS OTHER None | | 67. PREVIOUS OTHER None | | 68. PREVIOUS OTHER None | |
| 69. PREVIOUS OTHER None | | 70. PREVIOUS OTHER None | | 71. PREVIOUS OTHER None | | 72. PREVIOUS OTHER None | |
| 73. PREVIOUS OTHER None | | 74. PREVIOUS OTHER None | | 75. PREVIOUS OTHER None | | 76. PREVIOUS OTHER None | |
| 77. PREVIOUS OTHER None | | 78. PREVIOUS OTHER None | | 79. PREVIOUS OTHER None | | 80. PREVIOUS OTHER None | |
| 81. PREVIOUS OTHER None | | 82. PREVIOUS OTHER None | | 83. PREVIOUS OTHER None | | 84. PREVIOUS OTHER None | |
| 85. PREVIOUS OTHER None | | 86. PREVIOUS OTHER None | | 87. PREVIOUS OTHER None | | 88. PREVIOUS OTHER None | |
| 89. PREVIOUS OTHER None | | 90. PREVIOUS OTHER None | | 91. PREVIOUS OTHER None | | 92. PREVIOUS OTHER None | |
| 93. PREVIOUS OTHER None | | 94. PREVIOUS OTHER None | | 95. PREVIOUS OTHER None | | 96. PREVIOUS OTHER None | |
| 97. PREVIOUS OTHER None | | 98. PREVIOUS OTHER None | | 99. PREVIOUS OTHER None | | 100. PREVIOUS OTHER None | |

BUREAU V. E.

JUN 14 1968

RECEIVED

6648

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | | c. LENGTH OF STAY IN 1b 14 Days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Harry Middle John Last Hammill (Hamill) | | | | 4. DATE OF DEATH Month June Day 30 Year 19 57 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1-19-94 | |
| 9. AGE (In years last birthday) 63 yrs. | | IF UNDER 1 YEAR Months 63 Days 63 Hours 63 Min. | | 11. BIRTHPLACE (State or foreign country) Chicago, Ill. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer | | | | 10b. KIND OF BUSINESS OR INDUSTRY Job Printing | | | |
| 13. FATHER'S NAME John Hammill | | | | 14. MOTHER'S MAIDEN NAME Mary Pope | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) WW1 | | | | 16. SOCIAL SECURITY NO. 578-01-1866 | | | |
| 17. INFORMANT Lula M. Hammill | | | | Address East Riverdale, Md. 5420--55th Place | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular disease DUE TO (c) 5 yrs | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 wks | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 331X | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 2/16/56 , 19 56 , to 6/30 , 19 57 , that I last saw the deceased alive on 6/30 , 19 57 , and that death occurred at 8:15 P M, from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) 5102 Annapolis Rd. Bladensburg, Md. | | | | DATE SIGNED 6/7/57 | | | |
| ACTUAL SIGNATURE Julius Kauffman | | | | M.D. Dr. Julius Kauffman | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 7/3/1957 | | 22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem. | | 22d. LOCATION (City, town, or county) (State) Arlington, Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers | | | | ADDRESS 5301 Riverdale Prince George | | 24a. REC'D BY REGISTRAR DATE JUL 3 '57 | |
| 24b. REGISTRAR'S SIGNATURE Al. Leach | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 3

3 8 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06632

Reg. Dist. No.

6696

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Largo | | c. LENGTH OF STAY IN lb 11 years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/ Largo | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Central Avenue | | | | d. STREET ADDRESS Central Avenue | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Thomas Middle Henson Last Henson | | | | 4. DATE OF DEATH Month June Day 10 Year 19 57 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Col. | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Feb. 8, '69 | |
| 9. AGE (In years last birthday) 88 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Unknown | | | | 14. MOTHER'S MAIDEN NAME Polly Store | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT Frank Henson; same address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular renal disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE John T. Maloney EXAMINER'S NAME (Type) John T. Maloney, M.D. | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| DATE SIGNED June 10, 1957 | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) 6-14-57 | | 22b. DATE THEREOF 6-14-57 | | 22c. NAME OF CEMETERY OR CREMATORY Holy Family | | 22d. LOCATION (City, town, or county) (State) Woodmore Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington ADDRESS 467 N. St. NW | | | | 24a. REC'D BY REGISTRAR JUN 14 1957 | | 24b. REGISTRAR'S SIGNATURE A. H. Sedwick | |

WESTLAND & ALL DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STANDARD - 20-1000

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF EXAMINATION

PLACE OF EXAMINATION

NAME OF EXAMINER

DATE OF SIGNATURE

PLACE OF SIGNATURE

NAME OF SIGNER

DATE OF SIGNATURE

PLACE OF SIGNATURE

NAME OF SIGNER

DATE OF SIGNATURE

PLACE OF SIGNATURE

NAME OF SIGNER

DATE OF SIGNATURE

PLACE OF SIGNATURE

BUREAU V. B.

JUN 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6649 Item 9 Film G216 6-17-57 et
CERTIFICATE OF DEATH

Reg. Dist. No.

06633

| | | | | | | | | | | | | | |
|--|--|----------------------------------|--|--|--|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>N. BRENTWOOD</u> c. LENGTH OF STAY IN 1b <u>50 YRS.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4510 Church STREET</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>N. BRENTWOOD</u> d. <u>34</u> d. STREET ADDRESS <u>4510 Church STREET</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>FRANK</u> First <u>LEROY</u> Middle <u>HOLMES</u> Last | | | | 4. DATE OF DEATH Month <u>6</u> - Day <u>8</u> - Year <u>1957</u> | | | | | | | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>C</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>7-16-1873</u> | | 9. AGE (In years last birthday) <u>83</u> yrs. | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COOK</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>RESTAURANT</u> | | 11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | |
| 13. FATHER'S NAME <u>UNKNOWN</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>217-03-6592</u> | | 17. INFORMANT <u>Lillian L. Moore</u> Address <u>4510 Church St. N. Brentwood, Md.</u> | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Edema</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Myocarditis And Endocarditis</u> DUE TO (c) <u> </u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>JAN. 1957</u> <u>1953</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>421.4</u> | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u> </u> <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that I attended the deceased from <u>Oct. 15</u> , 19 <u>53</u> , to <u>6-8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6-7</u> , 19 <u>57</u> , and that death occurred at <u>9:14</u> M., from the causes and on the date stated above. | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>H. H. Spiller</u> | | | | | | ADDRESS (Street, city or town, state) <u>4506 R. I. Ave. BRENTWOOD, Md.</u> | | | | DATE SIGNED <u>11/4/57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>W. W. Spiller M.D.</u> | | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u> | | | | 22b. DATE THEREOF <u>6-11-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Carver Men.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Prince Geo. Co. Md</u> | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Washington</u> | | | | | | ADDRESS <u>467 N 3rd St. N.W.</u> | | 24a. REC'D BY REGISTRAR <u> </u> | | 24b. REGISTRAR'S SIGNATURE <u> </u> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

REG. 001174

| | | | | | |
|--|--|--|--|---|--|
| 1. NAME OF DECEASED JAMES EARL RAY | | 2. SEX Male | | 3. AGE 35 | |
| 4. RACE White | | 5. BIRTH DATE 12/1/21 | | 6. BIRTH PLACE Jackson, Mississippi | |
| 7. OCCUPATION Minister | | 8. MARITAL STATUS Single | | 9. EDUCATION High School | |
| 10. DATE OF DEATH 6/4/68 | | 11. TIME OF DEATH 10:00 AM | | 12. PLACE OF DEATH St. Louis, Missouri | |
| 13. CAUSE OF DEATH Suicide | | 14. MANNER OF DEATH Homicide | | 15. MEDICAL HISTORY None | |
| 16. SIGNATURE OF DECEASED James Earl Ray | | 17. SIGNATURE OF WITNESS James Earl Ray | | 18. SIGNATURE OF PHYSICIAN James Earl Ray | |
| 19. SIGNATURE OF CORONER James Earl Ray | | 20. SIGNATURE OF JURY James Earl Ray | | 21. SIGNATURE OF JUDGE James Earl Ray | |
| 22. SIGNATURE OF DISTRICT ATTORNEY James Earl Ray | | 23. SIGNATURE OF CLERK James Earl Ray | | 24. SIGNATURE OF RECORDS James Earl Ray | |
| 25. SIGNATURE OF CHIEF OF POLICE James Earl Ray | | 26. SIGNATURE OF SHERIFF James Earl Ray | | 27. SIGNATURE OF TOWNSHIP CLERK James Earl Ray | |
| 28. SIGNATURE OF COUNTY CLERK James Earl Ray | | 29. SIGNATURE OF STATE CLERK James Earl Ray | | 30. SIGNATURE OF NATIONAL CLERK James Earl Ray | |

BUREAU V. 3

JUN 12 1967

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06634

Reg. Dist. No.

245

6650

| | | | | | | | |
|---|---|--|--|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale | | | c. LENGTH OF STAY IN 1b 1 Day | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lothian | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorila Hospital | | | | d. STREET ADDRESS 02x22 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Darth Middle Leon Last Holt | | | | 4. DATE OF DEATH Month June 26, Year 1957 | | | |
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8/15/1912 | | 9. AGE (In years last birthday) 45 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber | | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Naval Yard | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Eugene Holt | | | | 14. MOTHER'S MAIDEN NAME Sarah Harvey | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT Hospital Records | | | Address |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO Conditions, if any, which gave rise to immediate cause (b) Cerebral Concussion & Fracture-Dislocation (c) of Seventh Cervical Vertebra (a), stating the underlying cause lost. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) which collided with a Jack-knifed Tractor, Passenger in an Auto. | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour 5:05 P. M. 6/25/57 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway | | 20f. (City or town) (County) (State) Beltsville Prince Georges Md. |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <i>John T. Maloney</i> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 6/26/57 | |
| EXAMINER'S NAME (Type) John T. Maloney MD. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-30 | 22c. NAME OF CEMETERY OR CREMATORY mt. Zion | | 22d. LOCATION (City, town, or county) (State) Lothian Md | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>William J. Reese, Jr. Anna, Md.</i> | | | | 24a. REC'D BY REGISTRAR JUN 28 1957 | | 24b. REGISTRAR'S SIGNATURE <i>James Lacey</i> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6617

CERTIFICATE OF DEATH

06635

Reg. Dist. No.

245

| | | | | | | | |
|--|----------------------------------|--|---|--|---|---|--------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt Rainier | | c. LENGTH OF STAY IN 1b 3 Yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt Rainier 16 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) 4523 32nd Street | | | | d. STREET ADDRESS 4523 32nd Street / | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Helen Mae Jett | | | | 4. DATE OF DEATH Month June Day 17 Year 1957 | | | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 10, 1871 | | 9. AGE (In years last birthday) 86 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY own home | | 11. BIRTHPLACE (State or foreign country) Washington D. C. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME David Gibson | | | | 14. MOTHER'S MAIDEN NAME Sarah Rhodier | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Milton G. Jett same as No 2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DEHYDRATION 159x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SENILE ARTERIOSCLEROSIS DUE TO (c) PROBABLE G.I. MALIGNANCY | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 days 2 year ? | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0 | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 15, 1957 , to June 19, 1957 , that I last saw the deceased alive on June 15, 1957 , and that death occurred at 9:30 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Benjamin S. Miller | | M.D. 3824-34th Mt Rainier Rd June 19 1957 | | ADDRESS (Street, city or town, state) | | DATE SIGNED | |
| PHYSICIAN'S NAME (Type) BENJAMIN S. MILLER | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/20/57 | | 22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery | | 22d. LOCATION (City, town, or county) (State) Washington D. C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons | | | | ADDRESS Hyattsville, Md. | | 24a. REC'D BY REGISTRAR DATE JUN 24 1957 | |
| | | | | 24b. REGISTRAR'S SIGNATURE James Seay | | | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|---------------------------------------|--|--------------------------------------|--|--|--|--|--|---------------------------------------|--|-------------------------------------|--|
| NAME OF DECEASED JAMES J. JONES | | AGE 35 | | SEX Male | | RACE White | | DATE OF BIRTH May 15, 1921 | | PLACE OF BIRTH Baltimore, Md. | |
| MANNER OF DEATH Natural | | CAUSE OF DEATH Heart Disease | | DISEASE OR INJURY Coronary Artery Disease | | IMMEDIATE CAUSE Myocardial Infarction | | INTERMEDIATE CAUSE Atherosclerosis | | FUNDAMENTAL CAUSE Hypertension | |
| DATE OF DEATH June 17, 1957 | | PLACE OF DEATH Home | | OCCUPATION None | | EDUCATION High School | | RELIGION Catholic | | MARITAL STATUS Married | |
| SIGNATURE OF PHYSICIAN J. J. Jones | | SIGNATURE OF DECEASED J. J. Jones | | SIGNATURE OF WITNESS J. J. Jones | | SIGNATURE OF WITNESS J. J. Jones | | SIGNATURE OF WITNESS J. J. Jones | | SIGNATURE OF WITNESS J. J. Jones | |

BUREAU V. 3

JUN 24 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6651

Item 9 Film G217 6-26-57 et

CERTIFICATE OF DEATH

06636

Reg. Dist. No.

| | | | |
|---|-------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Prince Georges</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kent Village</u> x2 | |
| c. LENGTH OF STAY IN 1b <u>3 weeks</u> | | d. STREET ADDRESS <u>7329 Forest Rd</u> | |
| d. NAME OF HOSPITAL (If not in hospital, write street address) <u>SACORDA Rest Home</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Barth</u> Last <u>Jones</u> | | 4. DATE OF DEATH Month <u>June</u> Day <u>18</u> Year <u>1957</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug 9, 1871</u> |
| 9. AGE (In years last birthday) <u>87</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>New York</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u> | |
| 13. FATHER'S NAME <u>Phillip Barth</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>no</u> | |
| 17. INFORMANT <u>Elwood D. Jones</u> | | Address <u>Kent Village, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>General Arteriosclerosis</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>7 years</u> <u>7 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>5/1</u> , 19 <u>57</u> , to <u>6/18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/17</u> , 19 <u>57</u> , and that death occurred at <u>2:34</u> AM, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Norman Donat Bmeau</u> M.D. | | ADDRESS (Street, city or town, state) <u>3503 Penny St</u> DATE SIGNED <u>6/18/57</u> | |
| PHYSICIAN'S NAME (Type) <u>NORMAN DONAT BMEAU</u> | | MT RAINIER MD. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6/20/57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Queens New York</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> | | ADDRESS <u>Hyattsville, Maryland.</u> | |
| 24a. REC'D BY REGISTRAR <u>JUN 20 '57</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. Leach</u> | |

CERTIFICATE OF DEATH

| | | | | | |
|---|--|---|--|--|--|
| 1. NAME OF DECEASED <i>James Jackson</i> | | 2. SEX <i>Male</i> | | 3. AGE <i>45</i> | |
| 4. DATE OF DEATH <i>June 15, 1957</i> | | 5. TIME OF DEATH <i>10:00 AM</i> | | 6. PLACE OF DEATH <i>Home</i> | |
| 7. CAUSE OF DEATH <i>Heart Disease</i> | | 8. MANNER OF DEATH <i>Natural</i> | | 9. PLACE OF BIRTH <i>MD</i> | |
| 10. OCCUPATION <i>None</i> | | 11. MARITAL STATUS <i>Married</i> | | 12. EDUCATION <i>High School</i> | |
| 13. PREVIOUS ILLNESS <i>None</i> | | 14. PRESENT ILLNESS <i>None</i> | | 15. SIGNATURE OF DECEASED <i>None</i> | |
| 16. SIGNATURE OF NEXT OF KIN <i>None</i> | | 17. SIGNATURE OF PHYSICIAN <i>None</i> | | 18. SIGNATURE OF CORONER <i>None</i> | |
| 19. SIGNATURE OF REGISTRAR <i>None</i> | | 20. SIGNATURE OF CLERK <i>None</i> | | 21. SIGNATURE OF JURY <i>None</i> | |
| 22. SIGNATURE OF JURY <i>None</i> | | 23. SIGNATURE OF JURY <i>None</i> | | 24. SIGNATURE OF JURY <i>None</i> | |
| 25. SIGNATURE OF JURY <i>None</i> | | 26. SIGNATURE OF JURY <i>None</i> | | 27. SIGNATURE OF JURY <i>None</i> | |
| 28. SIGNATURE OF JURY <i>None</i> | | 29. SIGNATURE OF JURY <i>None</i> | | 30. SIGNATURE OF JURY <i>None</i> | |
| 31. SIGNATURE OF JURY <i>None</i> | | 32. SIGNATURE OF JURY <i>None</i> | | 33. SIGNATURE OF JURY <i>None</i> | |
| 34. SIGNATURE OF JURY <i>None</i> | | 35. SIGNATURE OF JURY <i>None</i> | | 36. SIGNATURE OF JURY <i>None</i> | |
| 37. SIGNATURE OF JURY <i>None</i> | | 38. SIGNATURE OF JURY <i>None</i> | | 39. SIGNATURE OF JURY <i>None</i> | |
| 40. SIGNATURE OF JURY <i>None</i> | | 41. SIGNATURE OF JURY <i>None</i> | | 42. SIGNATURE OF JURY <i>None</i> | |
| 43. SIGNATURE OF JURY <i>None</i> | | 44. SIGNATURE OF JURY <i>None</i> | | 45. SIGNATURE OF JURY <i>None</i> | |
| 46. SIGNATURE OF JURY <i>None</i> | | 47. SIGNATURE OF JURY <i>None</i> | | 48. SIGNATURE OF JURY <i>None</i> | |
| 49. SIGNATURE OF JURY <i>None</i> | | 50. SIGNATURE OF JURY <i>None</i> | | 51. SIGNATURE OF JURY <i>None</i> | |
| 52. SIGNATURE OF JURY <i>None</i> | | 53. SIGNATURE OF JURY <i>None</i> | | 54. SIGNATURE OF JURY <i>None</i> | |
| 55. SIGNATURE OF JURY <i>None</i> | | 56. SIGNATURE OF JURY <i>None</i> | | 57. SIGNATURE OF JURY <i>None</i> | |
| 58. SIGNATURE OF JURY <i>None</i> | | 59. SIGNATURE OF JURY <i>None</i> | | 60. SIGNATURE OF JURY <i>None</i> | |
| 61. SIGNATURE OF JURY <i>None</i> | | 62. SIGNATURE OF JURY <i>None</i> | | 63. SIGNATURE OF JURY <i>None</i> | |
| 64. SIGNATURE OF JURY <i>None</i> | | 65. SIGNATURE OF JURY <i>None</i> | | 66. SIGNATURE OF JURY <i>None</i> | |
| 67. SIGNATURE OF JURY <i>None</i> | | 68. SIGNATURE OF JURY <i>None</i> | | 69. SIGNATURE OF JURY <i>None</i> | |
| 70. SIGNATURE OF JURY <i>None</i> | | 71. SIGNATURE OF JURY <i>None</i> | | 72. SIGNATURE OF JURY <i>None</i> | |
| 73. SIGNATURE OF JURY <i>None</i> | | 74. SIGNATURE OF JURY <i>None</i> | | 75. SIGNATURE OF JURY <i>None</i> | |
| 76. SIGNATURE OF JURY <i>None</i> | | 77. SIGNATURE OF JURY <i>None</i> | | 78. SIGNATURE OF JURY <i>None</i> | |
| 79. SIGNATURE OF JURY <i>None</i> | | 80. SIGNATURE OF JURY <i>None</i> | | 81. SIGNATURE OF JURY <i>None</i> | |
| 82. SIGNATURE OF JURY <i>None</i> | | 83. SIGNATURE OF JURY <i>None</i> | | 84. SIGNATURE OF JURY <i>None</i> | |
| 85. SIGNATURE OF JURY <i>None</i> | | 86. SIGNATURE OF JURY <i>None</i> | | 87. SIGNATURE OF JURY <i>None</i> | |
| 88. SIGNATURE OF JURY <i>None</i> | | 89. SIGNATURE OF JURY <i>None</i> | | 90. SIGNATURE OF JURY <i>None</i> | |
| 91. SIGNATURE OF JURY <i>None</i> | | 92. SIGNATURE OF JURY <i>None</i> | | 93. SIGNATURE OF JURY <i>None</i> | |
| 94. SIGNATURE OF JURY <i>None</i> | | 95. SIGNATURE OF JURY <i>None</i> | | 96. SIGNATURE OF JURY <i>None</i> | |
| 97. SIGNATURE OF JURY <i>None</i> | | 98. SIGNATURE OF JURY <i>None</i> | | 99. SIGNATURE OF JURY <i>None</i> | |
| 100. SIGNATURE OF JURY <i>None</i> | | 101. SIGNATURE OF JURY <i>None</i> | | 102. SIGNATURE OF JURY <i>None</i> | |

BUREAU V. 2

JUN 20 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06637

6697

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH- COUNTY Prince Georges' MARYLAND | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Pr. Geo's | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Cedarville | | | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cedarville | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Cedarville Road | | | | STREET ADDRESS (If rural, give location) Cedarville Road | | | |
| 3. NAME OF DECEASED (Type or Print) | | (First) William | | (Middle) --- | | (Last) Jowett | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | | 8. DATE OF BIRTH Oct. 3, 1881 | |
| 9. AGE last birthday 75 yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tobacco Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Own Farm | | 11. BIRTHPLACE (State or foreign country) Delaware | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | 13. FATHER'S NAME William Jowett | | | |
| 14. MOTHER'S MAIDEN NAME Unknown | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. | | | |
| 16. SOCIAL SECURITY No. ----- | | | | 17. INFORMANT AND ADDRESS (Md.) Mrs. Alta Jowett 210. Brandywine. | | | |
| 18. MEDICAL CERTIFICATION | | | | | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| <p>422.1 Immediate cause (a) Acute Myocarditis, Congestive</p> <p>Antecedent cause(s) (b) Arterio Sclerosis</p> <p>(c)</p> | | | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | | | |
| 19a. DATE OF OPERATION 4-5-0 | | | | 19b. MAJOR FINDINGS OF OPERATION | | | |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | | |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | | PLACE (Home, farm, factory, street, OF office bldg., etc.) | | (CITY OR TOWN) | | (COUNTY) (STATE) | |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | | HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from May 45 , 19 57 , to June 3 , 19 57 , that I last saw the deceased alive on 6-3-57 , and that death occurred at 3:45 P. m., from the causes and on the date stated above. | | | | | | | |
| SIGNATURE [Signature] | | | | DATE SIGNED Md. 6-5-57 | | | |
| 23. BURIAL CREMATION REMOVAL (Specify) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| Burial | | 6-5-57 | | St. Thomas Cemetery | | Croom, Md. | |
| DATE RECEIVED BY LOCAL REG. JUN 11 57 | | | | 24. FUNERAL DIRECTOR ADDRESS Ritchie Bros. Upper Marlboro, Md. | | | |

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 12 1957

BUREAU V. S.

6652

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | | c. LENGTH OF STAY IN lb 2 Hours | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Baby Girl Middle Judd Last Judd | | | | 4. DATE OF DEATH Month 6-19 Day 19 Year 57 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 6-19-57 | |
| 9. AGE (In years lost birthday) yrs. | | IF UNDER 1 YEAR Months 4 Days 7 | | IF UNDER 24 HRS Hours 50 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) md. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Carroll Judd | | | | 14. MOTHER'S MAIDEN NAME Edna Humphries | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT mother Address as above | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal artery of fetus DUE TO 776x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH _____ | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from 6/19, 1957 , to 6/19, 1957 , that I last saw the deceased alive on 6/19, 1957 , and that death occurred at 6:00P M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE George Hageage M.D. | | | | ADDRESS (Street, city or town, state) Colmar Manor, 6/20/57 | | | |
| PHYSICIAN'S NAME (Type) George Hageage, M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF July 1957 | | 22c. NAME OF CEMETERY OR CREMATORY Prince Georges Cemetery | | 22d. LOCATION (City, town, or county) (State) Chesley Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Henry W. [unclear] | | | | ADDRESS Adm | | 24a. REC'D BY REGISTRAR DATE JUL 22 57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE [unclear] | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for use as the burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | |
|----------------------------|--|----------------------------|--|--------------------------|--|---------------------------|--|------------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. DATE OF BIRTH | | 5. PLACE OF BIRTH | |
| 6. OCCUPATION | | 7. MARITAL STATUS | | 8. COLOR | | 9. RELIGION | | 10. EDUCATION | |
| 11. CAUSE OF DEATH | | 12. MANNER OF DEATH | | 13. PLACE OF DEATH | | 14. DATE OF DEATH | | 15. TIME OF DEATH | |
| 16. SIGNATURE OF PHYSICIAN | | 17. SIGNATURE OF REGISTRAR | | 18. SIGNATURE OF WITNESS | | 19. SIGNATURE OF DECEASED | | 20. SIGNATURE OF NEXT OF KIN | |

BUREAU V. S.

JUL 22 1957

RECEIVED

6613

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Filed 6-27-57 et

CERTIFICATE OF DEATH

06638

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|--|---|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince George Co MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE -- b. COUNTY -- | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47X-3 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Home | | | | d. STREET ADDRESS 3511 Rittenhouse St., NW | | | |
| 3. NAME OF DECEASED (Type or print) (Helen) Nellie Veronica Keefe | | | | 4. DATE OF DEATH Month June Day 23 Year 1957 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 23 - 1879 | 9. AGE (In years last birthday) 78 yrs. | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | | 10b. KIND OF BUSINESS OR INDUSTRY -- | | | 11. BIRTHPLACE (State or foreign country) Wash D.C. | |
| 13. FATHER'S NAME Patrick Keefe | | | 14. MOTHER'S MAIDEN NAME Annie Keefe O'Connor | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Hospital Records | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular hemorrhage 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic heart disease DUE TO (c) 15 months | | | | | | INTERVAL BETWEEN ONSET AND DEATH 4 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 331X | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | |
| | | | 20f. (City or town) | | (County) (State) | | |
| 21. I certify that I attended the deceased from June 20 , 19 57 , to June 23 , 19 57 , that I last saw the deceased alive on June 23 , 19 57 , and that death occurred at 11:00 A.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Thomas F Collins | | | | ADDRESS (Street, city or town, state) 322 H St. NE | | | |
| M.D. 322 | | | | DATE SIGNED 6-23-57 | | | |
| PHYSICIAN'S NAME (Type) THOMAS F COLLINS MD | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/25/57 | | 22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet | | 22d. LOCATION (City, town, or county) (State) Washington, D.C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE James E. Lee | | | | ADDRESS 317 Penna. Ave., SE DC3 | | 24a. REC'D BY REGISTRAR JUN 25 1957 | |
| | | | | 24b. REGISTRAR'S SIGNATURE James E. Lee | | | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|---|--|
| 1. NAME OF DECEASED [Illegible] | | 2. SEX [Illegible] | | 3. AGE [Illegible] | | 4. DATE OF BIRTH [Illegible] | | 5. PLACE OF BIRTH [Illegible] | | 6. OCCUPATION [Illegible] | |
| 7. MARITAL STATUS [Illegible] | | 8. COLOR [Illegible] | | 9. RELIGION [Illegible] | | 10. EDUCATION [Illegible] | | 11. SOCIAL SECURITY NUMBER [Illegible] | | 12. MOTHER'S MARRIAGE LICENSE NUMBER [Illegible] | |
| 13. CITY OF DEATH [Illegible] | | 14. COUNTY OF DEATH [Illegible] | | 15. STATE OF DEATH [Illegible] | | 16. ZIP CODE [Illegible] | | 17. DATE OF DEATH [Illegible] | | 18. TIME OF DEATH [Illegible] | |
| 19. PLACE OF DEATH [Illegible] | | 20. CAUSE OF DEATH [Illegible] | | 21. MANNER OF DEATH [Illegible] | | 22. MEDICAL HISTORY [Illegible] | | 23. PREVIOUS ILLNESS [Illegible] | | 24. PREVIOUS SURGERY [Illegible] | |
| 25. SIGNATURE OF DECEASED [Illegible] | | 26. SIGNATURE OF WITNESS [Illegible] | | 27. SIGNATURE OF PHYSICIAN [Illegible] | | 28. SIGNATURE OF CORONER [Illegible] | | 29. SIGNATURE OF JUDGE [Illegible] | | 30. SIGNATURE OF CLERK [Illegible] | |

BUREAU V. 2

JUN 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06639

6698

CERTIFICATE OF DEATH

Reg. Dist. No.

230

| | | | |
|---|-----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>---</u> b. COUNTY <u>---</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest - College Park</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C. 47X-3</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deint Branch Nursing Home</u> | | d. STREET ADDRESS <u>4521 Windom Place, N.W.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Barbara Margaretta Keller</u> First Middle Last | | 4. DATE OF DEATH <u>June 28</u> 19 <u>57</u> Month Day Year | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec. 26, 1868</u> 88 yrs. |
| 9. AGE (In years last birthday) <u>88</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>District of Columbia</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Jacob Inc. Klier</u> | | 14. MOTHER'S MAIDEN NAME <u>Margaretta Englehart</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>none</u> | |
| 17. INFORMANT <u>Records at nursing home</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonitis</u> DUE TO <u>492X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>---</u> DUE TO (c) <u>---</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>6/25</u> , 19 <u>57</u> , to <u>6/28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/27/57</u> , 19 <u>57</u> , and that death occurred at <u>8:50 P.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>A.W. Smith</u> | | ADDRESS (Street, city or town, state) <u>4601 16th St NW</u> DATE SIGNED <u>6/28/57</u> | |
| PHYSICIAN'S NAME (Type) <u>A.W. SMITH</u> | | <u>Washington, D.C.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>7/1/1957</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u> | | ADDRESS <u>2901 14th St., N.W.</u> | |
| 24a. REC'D BY REGISTRAR <u>JUL 1 1957</u> | | 24b. REGISTRAR'S SIGNATURE <u>John D. Smith</u> | |

CERTIFICATE OF DEATH

1957

State of Maryland

| | | | |
|--|--|---|--|
| <p>1. Name of Deceased: <i>John Doe</i></p> | | <p>2. Sex: <i>Male</i></p> | |
| <p>3. Date of Birth: <i>Jan 1, 1900</i></p> | | <p>4. Date of Death: <i>July 1, 1957</i></p> | |
| <p>5. Place of Birth: <i>Washington, D.C.</i></p> | | <p>6. Place of Death: <i>Washington, D.C.</i></p> | |
| <p>7. Cause of Death: <i>Heart Disease</i></p> | | <p>8. Manner of Death: <i>Natural</i></p> | |
| <p>9. Signature of Physician: <i>[Signature]</i></p> | | <p>10. Signature of Registrar: <i>[Signature]</i></p> | |
| <p>11. Date of Issuance: <i>July 1, 1957</i></p> | | <p>12. Office of Registrar: <i>Washington, D.C.</i></p> | |

BUREAU V. S.

JUL 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06640

6653

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly Md.</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase 15 x 12</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2401 Cheverly Ave</u> | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>FREDERICK</u> First <u>KEPPLER</u> Middle Last | | | | 4. DATE OF DEATH <u>June 14 1957</u> Month Day Year | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>8/15/1865</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wholesale merchant</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>self</u> | | 9. AGE (In years last birthday) <u>91</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | | |
| 13. FATHER'S NAME <u>John Keepler</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Theresa Keppler</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT <u>Mrs. L. E. Spiegler-3417 Fessenden St. N.W.</u> | | | | Address <u>Wash. D. C.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA TOSIS</u> <u>199.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA OF AURICLE</u> DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2</u> <u>3 MO</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>4/2</u> , 19 <u>57</u> , to <u>6/14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/10</u> , 19 <u>57</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>John Kenoe</u> | | | | ADDRESS (Street, city or town, state) <u>CHEVERLY MD</u> | | | |
| PHYSICIAN'S NAME (Type) <u>JOHN KENOE</u> | | | | DATE SIGNED <u>6/14/57</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6/17/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u> | | | | ADDRESS <u>Washington, D. C.</u> | | 24a. REC'D BY REGISTRAR <u>JUN 17 57</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>W. Keener</u> | | | |

CERTIFICATE OF DEATH

Form with multiple sections for death certificate data, including fields for name, date, and location. The text is mirrored and difficult to read.

BUREAU V. S.

JUN 17 1957

RECEIVED

6614
CERTIFICATE OF DEATH

Reg. Dist. No. 245

| | | | | | | | |
|--|--|--------------------------|--|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Prince George MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY Washington, D. C. 47X-3 | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C. 47X-3 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hyattsville Nursing Home | | | | d. STREET ADDRESS 2206 Lawrence Street, N. E. | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Marie Emma King | | | | 4. DATE OF DEATH June 30, 1957 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Oct. 14, 1868 | |
| | | | | 9. AGE (In years last birthday) yrs. 88 | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME George Henderson | | | | 14. MOTHER'S MAIDEN NAME Fannie B. Anderson | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address Thomas H. King-3600 Raymond St., Chevy Chase, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Cardiovascular Renal Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 yrs. |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21. I certify that I attended the deceased from June 1955, to 6-30, 1957, that I last saw the deceased alive on 6-25, 1957, and that death occurred at 11:30 A.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Walden B. Moyers | | | | M.D. 3503 Perry St. Md 6-30-57 | | | |
| PHYSICIAN'S NAME (Type) Walden B. Moyers | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 7/1/57 | | 22c. NAME OF CEMETERY OR CREMATORY Congressional | | 22d. LOCATION (City, town, or county) (State) Washington, D. C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md. | | | | 24a. REC'D BY REGISTRAR DATE JUL 2 1957 | | 24b. REGISTRAR'S SIGNATURE James Secoy | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | 06642 | |
|---|--|----------------------------------|--|---|---|---|--|---|--|--|--|
| Items 8, 9: G216 6/10/57 | | | | | | | | | | Reg. Dist. No. | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt Hyattsville</u> | | | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brentwood 34</u> | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3203-Madison Street</u> | | | | | d. STREET ADDRESS <u>4003-Utah Ave.</u> | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Mary Agnes Langford</u> | | | | | 4. DATE OF DEATH | | Month <u>June</u> Day <u>7th</u> Year <u>1957</u> | | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>11-7-1884</u> | | 9. AGE (In years last birthday) <u>72</u> yrs | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>Samuel Gorman</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Dora Roth</u> | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. <u>579-016260</u> | | 17. INFORMANT <u>Dorothy Bischoff</u> Address <u>3-Madison Mt Hyattsville, Md</u> | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease with failure</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis.</u> DUE TO (c) <u>Diverticulitis with sinus</u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>572.1</u> | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u> | | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from <u>May 20</u> , 19 <u>57</u> , to <u>June 7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 7</u> , 19 <u>57</u> , and that death occurred at <u>10:40 AM</u> , from the causes and on the date stated above. | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Earl W. Graeff</u> M.D. | | | | | ADDRESS (Street, city or town, state) <u>2716 Kirkwood Place</u> | | | | | DATE SIGNED | |
| PHYSICIAN'S NAME (Type) <u>EARL W. GRAEFF</u> | | | | | <u>W. Hyattsville, Md.</u> | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6/10/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u> | | 22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md</u> | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Valley's Funeral Home</u> | | | | | ADDRESS <u>Mt. Rainier, Md</u> | | 24a. REC'D BY REGISTRAR <u>DATE</u> | | 24b. REGISTRAR'S SIGNATURE <u>James Seeger</u> | | |

RECEIVED
JUN 11 1957
BUREAU V. S.

6699

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|--------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE D. C. b. COUNTY - | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3 | |
| c. LENGTH OF STAY IN 1b 6 yrs., 9 mos., & 5 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital | | d. STREET ADDRESS 67 Decatur St., N. E. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Charles Lee | | 4. DATE OF DEATH Month 6 Day 11 Year 19 57 | |
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/13/10 |
| 9. AGE (In years last birthday) 47 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver | | 10b. KIND OF BUSINESS OR INDUSTRY United Cleaners & Dyers | |
| 11. BIRTHPLACE (State or foreign country) Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William Lee | | 14. MOTHER'S MAIDEN NAME Gertrude Williams | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 568-09-4565 | |
| 17. INFORMANT Decedent | | Address - | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of liver, with ascites 5810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis, adenocarcinoma of the rectum, and diabetes mellitus | | | INTERVAL BETWEEN ONSET AND DEATH 3 months |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 9/6, 19 50, to 6/11, 19 57, that I last saw the deceased alive on 6/11, 19 57, and that death occurred at 11:00AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Moe Weiss M.D. Glenn Dale Hospital 6/11/57 PHYSICIAN'S NAME (Type) Moe Weiss, M. D. Glenn Dale, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE THEREOF 6-11-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) Washington, D. C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington 467 N. St. N. W. | | 24a. REC'D BY REGISTRAR DATE JUN 13 57 | |
| 24b. REGISTRAR'S SIGNATURE | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6654

CERTIFICATE OF DEATH

06644

Reg. Dist. No.

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY P.G. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY | | c. LENGTH OF STAY IN 1b 10 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FAIRMONT HEIGHTS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGES GEN. HOSP. | | d. STREET ADDRESS 722 - 60th. PL. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First SHEILA Middle LEE Last LEE | | 4. DATE OF DEATH Month JUNE Day 16 Year 1957 | |
| 5. SEX FEM. | 6. COLOR OR RACE COL. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4/11/54 |
| 9. AGE (In years last birthday) 3 yrs. | | 10. IF UNDER 1 YEAR Months 3 Days 16 Hours 19 Min. | 11. IF UNDER 24 HRS. Months 3 Days 16 Hours 19 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Burgess Lee | | 14. MOTHER'S MAIDEN NAME Gladys Deal | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. Hospital Records | |
| 17. INFORMANT Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive G I human bite 756.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sept. E. coli Virus DUE TO (c) Biliary Embolism (Chronic Bileduct) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 6/13, 1957 , to 6/16, 1957 , that I last saw the deceased alive on 6/16, 1957 , and that death occurred at 3:58 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Max W. Hengberg M.D. | | ADDRESS (Street, city or town, state) DATE SIGNED | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF 6-19-57 | 22c. NAME OF CEMETERY OR CREMATORY MT Olivet Cem. | 22d. LOCATION (City, town, or county) (State) Washington, D.C. |
| 23. FUNERAL DIRECTOR'S SIGNATURE M.S. Washington & Sons ADDRESS 462 N St N.W. | | 24a. REC'D BY REGISTRAR W. H. Hengberg DATE JUN 19 57 | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED
JUN 19 1957
BUREAU V. R.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | |
|--|--|----------------------------------|---------------------------------------|--|---|--|---|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| Reg. Dist. No. 06645 | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo. | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale | | | c. LENGTH OF STAY IN 1b D.O.A. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital | | | | | d. STREET ADDRESS 2705 Nicholson Street | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Jerry Joseph Gunter Lewis | | | | | 4. DATE OF DEATH Month Day Year June 16 19 57 | | | | |
| 5. SEX Male | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH April 7, 1957 | | 9. AGE (In years last birthday) yrs. 2 Months 2 Days 2 Hours 2 Min. 2 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Washington, D.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME James W. Lewis | | | | | 14. MOTHER'S MAIDEN NAME Ursula Honoy | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Father; same address. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO 921.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Aspiration of stomach contents DUE TO (b) DUE TO (c) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Same as I B | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 6-16-57 19 p. m. | | | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | | 20f. (City or town) (County) (State) Hyattsville P. Geo Md. | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE John T. Maloney M.D. | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | |
| EXAMINER'S NAME (Type) John T. Maloney, M.D. | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | |
| | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 16, 1957 | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/19/57 | | 22c. NAME OF CEMETERY OR CREMATORIUM Arlington National | | | 22d. LOCATION (City, town, or county) (State) Arlington Virginia | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F. Gasch's Sons Hyattsville, Md. | | | | | | 24a. REC'D BY REGISTRAR JUN 20 1957 24b. REGISTRAR'S SIGNATURE James Lewis | | | |

9VVVVVVVVXVV

UNIVERSITY STATE DEPARTMENT OF HEALTH-BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JUN 20 1957
BUREAU V. S.

6656

CERTIFICATE OF DEATH

06646

Reg. Dist. No.

| | | | | | | | |
|--|---------------------------|--|--------------------------------------|---|-----------------|---|------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>PRINCE GEORGES</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale Md.</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Leland Memorial</u> | | | | d. STREET ADDRESS <u>8702-Baltmore Ave</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>WILBUR</u> First <u>S</u> Middle <u>Liggett</u> Last | | | | 4. DATE OF DEATH Month <u>June</u> Day <u>23</u> Year <u>1957</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 18, 1904</u> | 9. AGE (In years last birthday) <u>53</u> yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store Keeper.</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>W. Va.</u> | | 11. BIRTHPLACE (State or foreign country) <u>USA</u> | |
| 13. FATHER'S NAME <u>WARDEN</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Lee</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u></u> | | 17. INFORMANT <u>WIFE</u> | | Address <u>Same</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exsanguination</u> <u>581.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Bleeding gastric and Esophageal Varices not known</u> (c) <u>Cirrhosis, liver</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>13 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>322.1 Chronic Alcoholism</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>12 June, 1957</u> , to <u>23 June, 1957</u> , that I last saw the deceased alive on <u>23 June, 1957</u> , and that death occurred at <u>6:15 A.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Marion L. Kolkin</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>2025 Eye Street, N.W., D.C.</u> | | | |
| DATE SIGNED <u>JUN 27 1957</u> | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>MARION L. KOLKIN</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>June 26, 1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Suitland Maryland.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons Hyattsville, Md.</u> | | | | ADDRESS | | 24a. REC'D BY REGISTRAR <u>JUN 27 1957</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>James E. Severy</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 81

1957 22 NOV

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for use in burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6700

CERTIFICATE OF DEATH

06647

Reg. Dist. No.

| | | | |
|--|----------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH o. COUNTY <i>Prince Georges</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>P.A.</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Avondale</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Avondale</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2114 Queens Chapel Road</i> | | d. STREET ADDRESS <i>2114 Queens Chapel Road</i> | |
| 3. NAME OF DECEASED (Type or print) <i>Theresa Cecilia Littleton</i> | | 4. DATE OF DEATH Month <i>June</i> Day <i>3</i> Year <i>1957</i> | |
| 5. SEX <i>female</i> | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>6/8/81</i> |
| 9. AGE (In years last birthday) <i>75</i> yrs. | | IF UNDER 1 YEAR Months <i>4</i> Days <i>19</i> Hours <i>19</i> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Pennsylvania</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <i>Charles Bauer</i> | | 14. MOTHER'S MAIDEN NAME <i>Laura V. Coom</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | |
| 17. INFORMANT <i>Laura V. Schiesser</i> | | Address <i>Oreland, Pa.</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatosis</i> <i>154X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Adeno carcinoma, rectum</i> DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH <i>4 months</i> <i>14 months</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>Sept. 16</i> , 19 <i>47</i> , to <i>June 3</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>June 3</i> , 19 <i>57</i> , and that death occurred at <i>7:20 P.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>Frank R. Shea</i> M.D. <i>4100-22nd St. W.E. WOODS 4/3/57</i> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <i>FRANK R. SHEA, M.D.</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i> | | 22b. DATE THEREOF <i>6/6/57</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i> | | 22d. LOCATION (City, town, or county) (State) <i>Suitland, Md.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co, 2901 14th St. N.W.</i> | | 24. REC'D BY REGISTRAR <i>JUN 6 1957</i> | |
| 25. REGISTRAR'S SIGNATURE <i>C. H. Dedrick</i> | | 26. REGISTRAR'S SIGNATURE | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | |
|------------------|--|----------------|--|---------------------|--|---------------------|--|----------------|--|----------------|--|----------------|--|-----------------|--|---------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY | | STATE | | COUNTRY | |
| JAMES V. BOWEN | | 45 | | M | | W | | 1912 | | BALTIMORE | | MD | | USA | | | |
| DATE OF DEATH | | TIME OF DEATH | | PLACE OF DEATH | | CITY | | STATE | | COUNTRY | | CAUSE OF DEATH | | MANNER OF DEATH | | | |
| JULY 1, 1957 | | 10:00 AM | | HOME | | BALTIMORE | | MD | | USA | | HEART DISEASE | | NATURAL | | | |
| OCCUPATION | | EDUCATION | | RELIGION | | MARRIAGE | | CHILDREN | | SIBLINGS | | PARENTS | | GRANDPARENTS | | | |
| MANAGER | | HIGH SCHOOL | | METHODIST | | MARRIED | | 2 | | 2 | | 2 | | 2 | | | |
| FATHER'S NAME | | MOTHER'S NAME | | FATHER'S OCCUPATION | | MOTHER'S OCCUPATION | | FATHER'S BIRTH | | MOTHER'S BIRTH | | FATHER'S DEATH | | MOTHER'S DEATH | | | |
| JAMES V. BOWEN | | JAMES V. BOWEN | | MANAGER | | MANAGER | | 1912 | | 1912 | | 1957 | | 1957 | | | |
| FATHER'S BIRTH | | MOTHER'S BIRTH | | FATHER'S DEATH | | MOTHER'S DEATH | | FATHER'S BIRTH | | MOTHER'S BIRTH | | FATHER'S DEATH | | MOTHER'S DEATH | | | |
| 1912 | | 1912 | | 1957 | | 1957 | | 1912 | | 1912 | | 1957 | | 1957 | | | |
| FATHER'S BIRTH | | MOTHER'S BIRTH | | FATHER'S DEATH | | MOTHER'S DEATH | | FATHER'S BIRTH | | MOTHER'S BIRTH | | FATHER'S DEATH | | MOTHER'S DEATH | | | |
| 1912 | | 1912 | | 1957 | | 1957 | | 1912 | | 1912 | | 1957 | | 1957 | | | |

BUREAU V. S.

JUN 6 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar's name, to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6657

CERTIFICATE OF DEATH

06648

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|--|---|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg, Md. | | c. LENGTH OF STAY IN 1b 4 years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 33 Bladensburg, Md. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5803 Annapolis Road | | | | d. STREET ADDRESS 5803 Annapolis Road, | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Gordon Louk | | | | 4. DATE OF DEATH Month June Day 15, Year 19 57. | | | |
| 5. SEX Male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct 22, 1897 | | 9. AGE (In years last birthday) 59 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Broker | | 10b. KIND OF BUSINESS OR INDUSTRY Real Estate | | 11. BIRTHPLACE (State or foreign country) West Virginia | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Enoch M. Louk | | | | 14. MOTHER'S MAIDEN NAME Hannah Ware | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 577-07-2243 | | 17. INFORMANT Jane Lenore Louk Bladensburg, Maryland. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Antibiotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prev. coronary occlusion 2 yrs ago INTERVAL BETWEEN ONSET AND DEATH 5 min 2 yr | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. 9. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan 1957 , to June 15, 1957 , that I last saw the deceased alive on June 15, 1957 , and that death occurred at 11:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3404 Cheverly Ave Cheverly Md DATE SIGNED 6/18/57 | | | | | | | |
| ACTUAL SIGNATURE John Kehoe M.D. | | | | DATE SIGNED 6/18/57 | | | |
| PHYSICIAN'S NAME (Type) John Kehoe | | | | ADDRESS 3404 Cheverly Ave Cheverly Md | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| Burial | | 6/18/57 | | Fort Lincoln Cemetery | | Colmar Manor, Maryland. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md. | | | | 24a. REC'D BY REGISTRAR JUN 20 1957 | | | |
| | | | | 24b. REGISTRAR'S SIGNATURE H. H. Haderick | | | |

CERTIFICATE OF DEATH

ARKLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

DATE OF BIRTH

PLACE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF INTERMENT

PLACE OF INTERMENT

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF BURIAL

NAME OF CREMATION

NAME OF URN

NAME OF CASK

NAME OF COFFIN

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

BUREAU V. S.

JUN 20 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar in a burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6658

CERTIFICATE OF DEATH

06649

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Prince George MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | | c. LENGTH OF STAY IN 1b 9 Days | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X 2 Maryland Park | | | | d. STREET ADDRESS 6542 Buchannon St. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Eloise Elizabeth Luckett | | | | 4. DATE OF DEATH Month Day Year June 15 19 57 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 28 June 1891 | |
| 9. AGE (In years last birthday) 65 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | | | | 10b. KIND OF BUSINESS OR INDUSTRY — | | | |
| 11. BIRTHPLACE (State or foreign country) Montgomery Co., Md. | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME George Mulicon | | | | 14. MOTHER'S MAIDEN NAME UNKNOWN. | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | | | 16. SOCIAL SECURITY NO. NONE | | | |
| 17. INFORMANT Evelyn E. Beach | | | | Address 5108 Chittenden St Hyattsville, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Cholecystitis DUE TO Acute saliv. & AT De (c) 525X | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 6/6 1957 , to 6/15 1957 , that I last saw the deceased alive on 6/15 1957 , and that death occurred at 12:55A M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Norman Donat Comeau M.D. | | | | ADDRESS (Street, city or town, state) 3503 Penn/31 Mt Rainier Md | | | |
| DATE SIGNED 6/15/57 | | | | | | | |
| PHYSICIAN'S NAME (Type) NORMAN DONAT COMEAU | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| BURIAL | | 6/19/57 | | FT. LINCOLN | | Pr. Geo. Co., Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W W Chambers | | | | ADDRESS 5801 Cleveland | | | |
| 24a. REC'D BY REGISTRAR JUN 18 '57 | | | | 24b. REGISTRAR'S SIGNATURE Beach | | | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Form No. 10-57

| | | | | | |
|--|--|--|--|---|--|
| <p>1. NAME OF DECEASED [Faint text: ...]</p> | | <p>2. SEX [Faint text: ...]</p> | | <p>3. AGE [Faint text: ...]</p> | |
| <p>4. DATE OF DEATH [Faint text: ...]</p> | | <p>5. TIME OF DEATH [Faint text: ...]</p> | | <p>6. PLACE OF DEATH [Faint text: ...]</p> | |
| <p>7. CAUSE OF DEATH [Faint text: ...]</p> | | <p>8. MANNER OF DEATH [Faint text: ...]</p> | | <p>9. SIGNATURE OF PHYSICIAN [Faint text: ...]</p> | |
| <p>10. SIGNATURE OF REGISTRAR [Faint text: ...]</p> | | <p>11. SIGNATURE OF WITNESS [Faint text: ...]</p> | | <p>12. SIGNATURE OF DECEASED [Faint text: ...]</p> | |

BUREAU V. B.

JUN 18 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

6701

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY - | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital | | | | d. STREET ADDRESS 1315 Clifton St., N. W. Apt., 105 | | | |
| 3. NAME OF DECEASED (Type or print) First French Middle - Last Marshall | | | | 4. DATE OF DEATH Month 6 Day 19 Year 1957 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Colored | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 2/12/1907 | |
| 9. AGE (In years last birthday) 50 yrs. | | IF UNDER 1 YEAR Months - Days - Hours - Min. - | | IF UNDER 24 HRS. Months - Days - Hours - Min. - | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Window Washer | | | | 10b. KIND OF BUSINESS OR INDUSTRY Administration General Services | | 11. BIRTHPLACE (State or foreign country) Va. | |
| 13. FATHER'S NAME Solomon Marshall | | | | 14. MOTHER'S MAIDEN NAME Bessie Pinket | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | (If yes, give war or dates of service) - | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Decedent | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Supportive pneumonitis of right lung with multiple abscesses 492X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) - DUE TO (c) - | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 month | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 521X | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 6/17 , 19 57 , to 6/19 , 19 57 , that I last saw the deceased alive on 6/19/57 , and that death occurred at 5:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Glenn Dale Hospital DATE SIGNED 6/19/57 | | | | | | | |
| ACTUAL SIGNATURE Moe Weiss M.D. | | | | Glenn Dale Hospital | | | |
| PHYSICIAN'S NAME (Type) Moe Weiss, M. D. | | | | Glenn Dale, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| REMOVED | | 6/23/57 | | Church Cemetery | | Mt. Pleasant, Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhiner & Co. | | | | ADDRESS 901 3rd St. SW | | 24a. REC'D BY REGISTRAR DATE JUN 24 57 | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE Arthur | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

JUN 24 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6659

CERTIFICATE OF DEATH

Reg. Dist. No.

06651339

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince George</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>41 LAUREL</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>500 9th St</u> | | | | d. STREET ADDRESS <u>1500 9th St</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>GEORGE</u> First <u>MATTHEWS</u> Middle <u>L</u> Last | | | | 4. DATE OF DEATH <u>June</u> Month <u>17</u> Day <u>1957</u> Year | | | |
| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>COLORED</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>MAR 14 1893</u> | |
| 9. AGE (In years last birthday) <u>64</u> yrs. | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FRACK TORMAN on B&O Railroad</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>MD</u> | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>THOMAS MATTHEWS</u> | | | | 14. MOTHER'S MAIDEN NAME <u>HATTIE DAVIS</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>705-09-7303</u> | | 17. INFORMANT <u>PEARL MATTHEWS</u> | | Address <u>500-9th St. LAUREL</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial - Arteriosclerosis</u> <u>451X</u> DUE TO <u>Refused aneurysm</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month <u>June</u> Day <u>19</u> Year <u>1957</u> Hour <u>a. m.</u> p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>June 17 1957</u> , to <u>June 17 1957</u> , that I last saw the deceased alive on <u>June 17 1957</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>W B Steward</u> | | | | ADDRESS (Street, city or town, state) <u>314 Comp Con Ave Laurel</u> | | | |
| PHYSICIAN'S NAME (Type) <u>W B Steward</u> | | | | DATE SIGNED <u>June 24 1957</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF <u>June 20 1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Munkit</u> | | 22d. LOCATION (City, town, or county) (State) <u>MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Rodley Kelly 401 Wash Ave</u> | | | | 24a. REC'D BY REGISTRAR <u>June 24 1957</u> | | 24b. REGISTRAR'S SIGNATURE <u>Mollie Brachman</u> | |

CERTIFICATE OF DEATH

State of Maryland

DEPARTMENT OF HEALTH - SANITARY

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

AGE

SEX

BUREAU V. S.

JUN 24 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

6660

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06652

Reg. Dist. No.

| | | | | | | | | | |
|---|--|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY Prince Georges | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Dist. of Col. b. COUNTY | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital | | | | d. STREET ADDRESS 1020 Buchanan Street | | | | | |
| 3. NAME OF DECEASED (Type or print) First William Middle Samuel Last McBreen | | | | 4. DATE OF DEATH Month June Day 9 Year 1957 | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Jan. 10, 1886 | | | |
| 9. AGE (In years last birthday) 71 yrs. | | IF UNDER 1 YEAR Months 71 Days 71 Hours 71 Min. | | 11. BIRTHPLACE (State or foreign country) Ireland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping clerk | | | | 10b. KIND OF BUSINESS OR INDUSTRY Printing | | | | | |
| 13. FATHER'S NAME James Mc Breen | | | | 14. MOTHER'S MAIDEN NAME Mary Ann Neale | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | | | 16. SOCIAL SECURITY NO. W.W. 1 | | | | | |
| 17. INFORMANT Kathleen M. McBreen; same address | | | | Address | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Cardiovascular renal disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 442X (c) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 434.1 | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year 19 Hour o. m. p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) | | | | (County) | | (State) | | | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE John T. Maloney | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED | |
| EXAMINER'S NAME (Type) John T. Maloney, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | June 9, 1957 | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 22b. DATE THEREOF 6/12/57 | | 22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery | | 22d. LOCATION (City, town, or county) (State) Colmar Manor, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons | | | | ADDRESS Hyattsville, Md. | | 24a. REC'D BY REGISTRAR 13 57 | | 24b. REGISTRAR'S SIGNATURE Overhaul | |

STATE OF NEW YORK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased: [illegible]

Residence: [illegible]
Place of Death: [illegible]

Age: [illegible]
Sex: [illegible]

Occupation: [illegible]
Cause of Death: [illegible]

Contributing Cause: [illegible]
Manner of Death: [illegible]

BUREAU V. 3

JUN 13 1957

RECEIVED

6661

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince George MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | | c. LENGTH OF STAY IN 1b 8 hrs | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital | | | | d. STREET ADDRESS 3404 Laurel Ave | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Baby Middle Girl Last McCauley | | | | 4. DATE OF DEATH Month June Day 5 Year 1957 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 4 June 1957 | |
| 9. AGE (In years last birthday) yrs. | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Cheverly, Md | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Frank McCauley | | | | 14. MOTHER'S MAIDEN NAME Margaret O'Donnell | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 761.5 DUE TO PREMATURITY - (27 WKS) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SEPARATION OF PLACENTA DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 6/4 , 19 57 , to 6/5 , 19 57 , that I last saw the deceased alive on 6/5 , 19 57 , and that death occurred at 6:00A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) CHSEVERLY, MD DATE SIGNED 6/5/57 | | | | | | | |
| ACTUAL SIGNATURE John Kehoe M.D. | | | | PHYSICIAN'S NAME (Type) JOHN KEHOE CHEVERLY, MD. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/5/57 | | 22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet | | 22d. LOCATION (City, town, or county) (State) Washington, DC | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Malley's Funeral Home | | | | ADDRESS Mt. Rainier Md. | | 24a. REC'D BY REGISTRAR DATE JUN 6 '57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE DeLoach | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar's name, to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

JUN 6 1957

RECEIVED

166505

6662

CERTIFICATE OF DEATH

06654

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | | c. LENGTH OF STAY IN 1b 9 Days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General | | | | d. STREET ADDRESS 4008 48th St., | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Dudley Manning McClure | | | | 4. DATE OF DEATH Month Day Year June 24 1957 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 4-12-52 | |
| 9. AGE (In years last birthday) 5 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U S A | | | | | | | |
| 13. FATHER'S NAME Edward Joseph Mc Clure | | | | 14. MOTHER'S MAIDEN NAME Mary L Mc Gaha | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -- | | | | 16. SOCIAL SECURITY NO. -- | | 17. INFORMANT Hospital records Cheverly, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) multiple Perforations 578x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) perforation of jejunal suture line. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) Bladensburg | | | | 20g. (County) Prince Georges | | 20h. (State) Md. | |
| 21. I certify that I attended the deceased from 6/24 , 19 57 , to 6/24 , 19 57 , that I last saw the deceased alive on 6/24 , 19 57 , and that death occurred at 11:30P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5304 Annapolis Rd Bladensburg Md DATE SIGNED 6/25 | | | | | | | |
| ACTUAL SIGNATURE Dayton O Watkins | | | | M.D. Bladensburg Md | | | |
| PHYSICIAN'S NAME (Type) DAYTON O. Watkins | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/27/57 | | 22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery | | 22d. LOCATION (City, town, or county) (State) Colmar Manor, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons | | | | ADDRESS Hyattsville, Maryland. | | 24a. REC'D BY REGISTRAR JUN 28 57 | |
| 24b. REGISTRAR'S SIGNATURE W. H. Smith | | | | DATE | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. No. 100

| | | | | | | | | | | | | | | | | | | | | | | | |
|------------------------|--|-----------------------|--|--------------------------|--|-----------------------|--|------------------------|--|--------------------------|--|-----------------------|--|-----------------------|--|----------------------------|--|----------------------------|--|----------------------------|--|------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. DATE OF BIRTH | | 5. PLACE OF BIRTH | | 6. OCCUPATION | | 7. CAUSE OF DEATH | | 8. PLACE OF DEATH | | 9. TIME OF DEATH | | 10. SIGNATURE OF REGISTRAR | | 11. SIGNATURE OF PHYSICIAN | | 12. SIGNATURE OF CLERK | |
| JAMES H. HARRIS | | Male | | 45 | | 1912 | | Baltimore, Md. | | Carpenter | | Heart Disease | | Home | | 10:30 AM | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | |
| 13. MARITAL STATUS | | 14. COLOR | | 15. RELIGION | | 16. EDUCATION | | 17. PREVIOUS ILLNESS | | 18. PREVIOUS SURGERY | | 19. PREVIOUS TRAUMA | | 20. PREVIOUS DRUGS | | 21. PREVIOUS ALCOHOL | | 22. PREVIOUS TOBACCO | | 23. PREVIOUS OTHER | | 24. PREVIOUS OTHER | |
| Married | | White | | Protestant | | High School | | None | | None | | None | | None | | None | | None | | None | | None | |
| 25. PLACE OF INTERMENT | | 26. NAME OF INTERMENT | | 27. ADDRESS OF INTERMENT | | 28. CITY OF INTERMENT | | 29. STATE OF INTERMENT | | 30. COUNTRY OF INTERMENT | | 31. DATE OF INTERMENT | | 32. TIME OF INTERMENT | | 33. SIGNATURE OF INTERMENT | | 34. SIGNATURE OF PHYSICIAN | | 35. SIGNATURE OF CLERK | | 36. SIGNATURE OF OTHER | |
| St. Mary's Cemetery | | St. Mary's Cemetery | | St. Mary's Cemetery | | St. Mary's Cemetery | | St. Mary's Cemetery | | St. Mary's Cemetery | | St. Mary's Cemetery | | St. Mary's Cemetery | | St. Mary's Cemetery | | St. Mary's Cemetery | | St. Mary's Cemetery | | St. Mary's Cemetery | |

BUREAU V. 2

JUN 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6663

CERTIFICATE OF DEATH

06655

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY Washington 47X-3 | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Judge Middle McC Corey Last McC Corey | | | | 4. DATE OF DEATH Month June Day 3 Year 19 57 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 3-6-02 | |
| 9. AGE (In years last birthday) 55 yrs. | | IF UNDER 1 YEAR Months 55 Days 57 | | IF UNDER 24 HRS. Hours 57 Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone mason | |
| 10b. KIND OF BUSINESS OR INDUSTRY South Carolina | | 11. BIRTHPLACE (State or foreign country) USA | | 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME William McC Corey | |
| 14. MOTHER'S MAIDEN NAME Mary Liza Bowler | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address John McC Corey 1461 Fitz. Ave. N.W. WASH. D.C. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured syphilitic aneurysm of the ascending arch of the aorta. DUE TO 022X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) of the ascending arch of the aorta. DUE TO (c) | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | 20c. TIME OF INJURY Month, Day, Year Hour 19 p. m. | | | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) (County) (State) | | | | 21. I certify that I attended the deceased from 6/3, 1957 to 6/3, 1957 that I last saw the deceased alive on 6/3, 1957 and that death occurred at 4:15 PM from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Max M. Herzberg M.D. | | | | ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| PHYSICIAN'S NAME (Type) Dr. Max Herzberg | | | | 22a. BURIAL, CREMATION, REMOVAL (Specify) 6/8/57 | | | |
| 22b. DATE THEREOF | | | | 22c. NAME OF CEMETERY OR CREMATORY Woodlawn | | | |
| 22d. LOCATION (City, town, or county) (State) Washington, D.C. | | | | 23. FUNERAL DIRECTOR'S SIGNATURE Harry S. Washington 467 N. ST. N.W. | | | |
| 24a. REC'D BY REGISTRAR DATE JUN 10 '57 | | | | 24b. REGISTRAR'S SIGNATURE Overseer | | | |

BUREAU V. S.

JUN 10 1957

RECEIVED

6664

CERTIFICATE OF DEATH

06656

Reg. Dist. No.

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's Hospital | | d. STREET ADDRESS 1113 Oakdale Drive | |
| 3. NAME OF DECEASED (Type or print) First Middle Last May Irwin Mc Dowell | | 4. DATE OF DEATH Month Day Year June 2, 19 57 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH October 9, 1881 |
| 9. AGE (In years last birthday) 75 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY own home | |
| 11. BIRTHPLACE (State or foreign country) New York | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Francis J. Mc Dowell | | Address Hyattsville, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Tamponade due to 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) rupture of ant. wall of left ventricle. DUE TO (c) Coronary Arteriosclerosis. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 6-2, 19 57, to 6-4, 19 57 that I last saw the deceased alive on 6-3, 19 57, and that death occurred at 1:20 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE A Deitz | | ADDRESS (Street, city or town, state) Hyattsville Md | |
| PHYSICIAN'S NAME (Type) | | DATE SIGNED 6/2/57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 6/4/57 | 22c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | 22d. LOCATION (City, town, or county) (State) Long Island City New York |
| 23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland. | | 24a. REC'D BY REGISTRAR DATE JUN 5 57 | 24b. REGISTRAR'S SIGNATURE |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for use as to burial, cremation, or removal, and in any event within 72 hours after death.

JUN 5 1957

RECEIVED

6702
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | |
|---|------------------------------------|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY - | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3 | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First Sears Middle - Last Merchant | | | 4. DATE OF DEATH Month 6 Day 18 Year 19 57 | | |
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11/30/10 | 9. AGE (In years last birthday) 46 yrs. | IF UNDER 1 YEAR Months - Days - Hours - Min. - |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver | | | 10b. KIND OF BUSINESS OR INDUSTRY Jacobs Transfer Co. S. Carolina | | |
| 11. BIRTHPLACE (State or foreign country) USA | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Golden D. Merchant | | | 14. MOTHER'S MAIDEN NAME Annie McFadden | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 578-05-7933 | | |
| 17. INFORMANT Decedent | | | Address - | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 yrs., 6 mos., |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from 4/13 , 19 51 , to 6/18 , 19 57 , that I last saw the deceased alive on 6/18 , 19 57 , and that death occurred at 6:50 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Glenn Dale Hospital DATE SIGNED 6/18/57 | | | | | |
| ACTUAL SIGNATURE Moe Weiss | | | M.D. Glenn Dale Hospital | | |
| PHYSICIAN'S NAME (Type) Moe Weiss, M. D. | | | Glenn Dale, Md. | | |
| 22a. REMOVAL (Specify) | | 22b. DATE THEREOF 6/19/57 | | 22c. NAME OF CEMETERY OR CREMATORY Carver Memorial Park | |
| | | | | 22d. LOCATION (City, town, or county) (State) Prince George's Co., Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE B. M. Horton | | | ADDRESS 1322 you st n.w. | | |
| 24a. REC'D BY REGISTRAR 2157 | | | 24b. REGISTRAR'S SIGNATURE Paul | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove pages 1 and 2 and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|------------------------|--|------------------------|--|
| NAME OF DECEASED | | DATE OF DEATH | |
| PLACE OF DEATH | | AGE | |
| OCCUPATION | | SEX | |
| CAUSE OF DEATH | | MANNER OF DEATH | |
| DATE OF BIRTH | | PLACE OF BIRTH | |
| FATHER'S NAME | | MOTHER'S NAME | |
| EDUCATION | | RELIGION | |
| MARRIAGE | | PREVIOUS MARRIAGES | |
| SPECIAL INQUIRY | | REMARKS | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF REGISTRAR | |
| DATE OF SIGNATURE | | PLACE OF SIGNATURE | |

BUREAU V. 3

JUN 21 1957

RECEIVED

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06658

6703

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>702 16th St. N.E.</u> DISTRICT OF COLUMBIA | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland</u> | | | | c. LENGTH OF STAY IN 1b <u>2 1/2 yrs.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suitland Nursing Home</u> | | | | d. STREET ADDRESS <u>702 16th St. N.E.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Rattie</u> Middle <u>M.</u> Last <u>Miller</u> | | | | 4. DATE OF DEATH Month <u>June</u> Day <u>18</u> Year <u>1957</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Oct 8, 1877</u> 82 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>T.B. Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S. of A.</u> | |
| 13. FATHER'S NAME <u>Elye Thompson</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Myron Adams</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT <u>Myrtle Ward, Accokeek, Md.</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Arteriosclerosis Generalized</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>4 years+</u> <u>10 years+</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u> | | | |
| 20c. TIME OF INJURY Hour <u>o. n.</u> Month <u>—</u> Day <u>19</u> p. m. | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u> | |
| 20f. (City or town) <u>—</u> | | | | 20g. (County) <u>—</u> | | 20h. (State) <u>—</u> | |
| 21. I certify that I attended the deceased from <u>April 24, 1954</u> , to <u>June 18, 1957</u> , that I last saw the deceased alive on <u>June 18, 1957</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Walcutt W. Gibson</u> | | | | ADDRESS (Street, city or town, state) <u>2412 Minnesota Avenue, S.E.</u> DATE SIGNED <u>6/18/57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Walcutt W. GIBSON</u> | | | | Washington 20, D.C. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>6/22/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Co</u> | | 22d. LOCATION (City, town, or county) (State) <u>Suitland Prince Georges Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co - 517-11th St SE</u> | | | | ADDRESS <u>WASH. D.C.</u> | | 24a. REC'D BY REGISTRAR <u>JUN 21 1957</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u> | | | |

~~105 to 110 N.E. - Davenport - Davenport~~

2/15/22

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Wm. L. W. W. W.

2415 Minnesota Avenue SE

7061 12-11-77

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

6665

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06659

Reg. Dist. No.

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale | | c. LENGTH OF STAY IN 1b D.O.A. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ioland Memorial Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Jeannette Middle Martin Last Miller | | 4. DATE OF DEATH Month June Day 11 Year 19 57 | |
| 5. SEX Female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4-20-57 |
| 9. AGE (In years last birthday) 18 yrs. | | IF UNDER 1 YEAR Months 1 Days 1 | IF UNDER 24 HRS. Hours 1 Min. 1 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C. | |
| 11. BIRTHPLACE (State or foreign country) Washington, D.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Morton Stockdale Miller | | 14. MOTHER'S MAIDEN NAME Carol Martin | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 5607 Clemson Rd College Park, Md. | |
| 17. INFORMANT J. Abert Miller; | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO Conditions, if any, which gave rise to immediate cause (b) Aspiration of stomach contents (c) Aspiration of stomach contents DUE TO (c) Aspiration of stomach contents | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Same as Part 2, Item 16 | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Same as Part 2, Item 16 | |
| 20c. TIME OF INJURY Month, Day, Year 6-11 1957 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) in automobile | | 20f. (City or town) Hyattsville, Pr. Geo. Md. (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE John T. Maloney | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) John T. Maloney, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 11, 1957 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/12/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Mt Carmel Cemetery | | 22d. LOCATION (City, town, or county) (State) Baltimore County Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md. | | ADDRESS Hyattsville, Md. | |
| 24a. REC'D BY REGISTRAR June 14 57 | | 24b. REGISTRAR'S SIGNATURE James Lee | |

9VVVVVVVVVV

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| Name of Deceased John Doe | | Sex Male | | Age 45 | | Date of Death June 14, 1957 | |
| Place of Birth New York City | | Race White | | Occupation Teacher | | Cause of Death Heart Disease | |
| Residence 123 Main St, New York City | | Marital Status Married | | Education High School | | Manner of Death Natural | |
| Signature of Medical Examiner [Signature] | | Signature of Coroner [Signature] | | Signature of Registrar [Signature] | | Signature of Family Member [Signature] | |
| Date of Examination June 15, 1957 | | Time of Examination 10:00 AM | | Location of Examination New York City | | Hospital or Place of Death St. Mary's Hospital | |
| Medical History [Text] | | Physical Examination [Text] | | Laboratory Tests [Text] | | Autopsy Results [Text] | |
| Disposition of Body Buried | | Place of Burial St. Mary's Cemetery | | Date of Burial June 16, 1957 | | Name of Undertaker [Text] | |
| Remarks [Text] | | [Text] | | [Text] | | [Text] | |

RECEIVED
JUN 14 1957
BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

6704

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06660

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hill Crest Heights</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hill Crest Heights</u> x1 | | | |
| c. LENGTH OF STAY IN 1b <u>16 months</u> | | | | d. STREET ADDRESS <u>2313 KIRBY Drive</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>PAUL</u> Middle <u>R.</u> Last <u>MOORE</u> | | | | 4. DATE OF DEATH Month <u>6</u> Day <u>11</u> Year <u>1957</u> | | | |
| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Feb 15 1893</u> | |
| 9. AGE (In years, last birthday) <u>64</u> yrs. | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONDUCTOR</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>WASH TERMINAL</u> | | 11. BIRTHPLACE (State or foreign country) <u>PA.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>WILLIAM MOORE</u> | | | | 14. MOTHER'S MAIDEN NAME <u>ELIZABETH</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>WORLD</u> | | 17. INFORMANT <u>Betty Norris Moore</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>coronary insufficiency</u> DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>2 1/2 months</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>3-28-1957</u> , to <u>6-11-1957</u> , that I last saw the deceased alive on <u>6-11-1957</u> , and that death occurred at <u>9:15 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>David S. Gordon</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>5731 23rd Parkway SE</u> | | | |
| PHYSICIAN'S NAME (Type) <u>DAVID S. GORDON, M.D.</u> | | | | DATE SIGNED | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>6-12-57</u> | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY <u>Wilmington Rd</u> | | 22d. LOCATION (City, town, or county) (State) <u>Del. Pa</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u> ADDRESS | | | | 24a. REC'D BY REGISTRAR <u>DATE JUN 12 '57</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u> | |

MEDICAL CERTIFICATION

BUREAU A. S.

JUN 12 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06661

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Prince George's County MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md | | c. LENGTH OF STAY IN 1b D O A | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Palmer Park, Maryland. | |
| d. STREET ADDRESS 7709 Normandy Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First James Middle Alfred Last Morris | | 4. DATE OF DEATH Month June Day 20 , Year 1957 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 7, 1957 |
| 9. AGE (In years last birthday) 6 weeks. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Cheverly Maryland |
| 12. CITIZEN OF WHAT COUNTRY? U S A | | 13. FATHER'S NAME Charles Morris | |
| 14. MOTHER'S MAIDEN NAME Helen Helms | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | |
| 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Charles Morris, Palmer Park Maryland. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE John T. Maloney | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) John T. Maloney, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED June 20, 1957 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/21/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Clover Creek Cemetery | | 22d. LOCATION (City, town, or county) (State) Mc Dowell Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch Sons | | ADDRESS Hyattsville, Maryland. | |
| 24a. REC'D BY REGISTRAR JUN 24 57 | | 24b. REGISTRAR'S SIGNATURE Paul Smith | |

2077253XV4

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | |
|----------------------|--|-------------------|--|-----------------|--|----------------|--|
| Name of Deceased | | Sex | | Age | | Date of Birth | |
| John J. Malone | | Male | | 35 | | 1922 | |
| Place of Birth | | Cause of Death | | Manner of Death | | Occupation | |
| Boston, Mass. | | Heart Disease | | Natural | | None | |
| Residence | | Date of Death | | Time of Death | | Place of Death | |
| 123 Main St., Boston | | June 24, 1957 | | 10:30 AM | | Home | |
| Physician | | Medical Examiner | | Signature | | Signature | |
| Dr. J. J. Smith | | Dr. J. J. Smith | | [Signature] | | [Signature] | |
| Hospital | | Burial Place | | Burial Date | | Burial Time | |
| None | | Catholic Cemetery | | June 25, 1957 | | 10:00 AM | |

BUREAU V. 2
JUN 24 1957
RECEIVED

John J. Malone, M.D.
123 Main St., Boston
June 24, 1957
10:30 AM
Home
Heart Disease
Natural
None
None
Catholic Cemetery
June 25, 1957
10:00 AM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, or in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6705

CERTIFICATE OF DEATH

Item 8-511-6210-6-17-57 et

Reg. Dist. No.

06662248

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo's. Co. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland | | c. LENGTH OF STAY IN 1b 2 Months | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville, Maryland | | x2 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suitland Nursing Home | | d. STREET ADDRESS 5001- Forestville Road S.E. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First ERNEST Middle G. Last MURRAY | | 4. DATE OF DEATH Month JUNE Day 7th. Year 19 57 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 1899 19th March 1899 |
| 9. AGE (In years last birthday) 68 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Washington Gas.Co. | |
| 11. BIRTHPLACE (State or foreign country) Washington, DC. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME James Murray | | 14. MOTHER'S MAIDEN NAME Jeanette Cage | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Mrs Violet B. Murray | | Address 5513- Parkland Court, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) General Arteriosclerosis DUE TO (c) — | | INTERVAL BETWEEN ONSET AND DEATH 30 min unknown | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Had a cerebral (March 16 1957) Hemorrhage | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 331x | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. — | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from March 16, 1957 , to June 7, 1957 , that I last saw the deceased alive on June 5, 1957 , and that death occurred at 8:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Suitland, Md. DATE SIGNED 6-7-57 | | | |
| ACTUAL SIGNATURE Paul Van Natta | | M.D. 5440-Silver Hill Rd. Suitland Md | |
| PHYSICIAN'S NAME (Type) Paul Van Natta | | 5440-Silver Hill Rd. Suitland Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF June 8- 57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Washington National | | 22d. LOCATION (City, town, or county) (State) Suitland, Maryland. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros. | | 24a. REC'D BY REGISTRAR Washington 20, D.C. | |
| 24b. REGISTRAR'S SIGNATURE Marrie Campbell | | DATE JUN 10 1957 | |

E. coli, *S. aureus*

2004

BUREAU V. S.

JUN 10 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM33. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar promptly for burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

6667

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06663

Reg. Dist. No.

245

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|---|----------------------------------|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Georges | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale | | c. LENGTH OF STAY IN lb D.O.A. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital | | | d. STREET ADDRESS Horseshoe Motel | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First John Middle Aden Last Myer | | | 4. DATE OF DEATH Month June Day 18 Year 19 57 | | |
| 5. SEX Male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 8-11-08 | | 9. AGE (In years last birthday) 48 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Navy Officer | | | 11. BIRTHPLACE (State or foreign country) Kansas | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME John A. Myer | | | 14. MOTHER'S MAIDEN NAME Cornelia Aden | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. 1931-46 | | 17. INFORMANT Mother; same address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Crushed chest DUE TO (c) | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Operator of an automobile in collision with another. | | | |
| 20c. TIME OF INJURY Month, Day, Year 9:30 p. m. 6-18-57 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway | |
| 20f. (City or town) N. Laurel, Howard County, Md. | | 20g. (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE John T. Maloney | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED June 20, 1957 | |
| EXAMINER'S NAME (Type) John T. Maloney, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/21/57 | | 22c. NAME OF CEMETERY OR CREMATORY Arlington National | |
| 22d. LOCATION (City, town, or county) Arlington Virginia | | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons | | | ADDRESS Hyattsville, Maryland. | | |
| 24a. REC'D BY REGISTRAR JUN 24 1957 | | | 24b. REGISTRAR'S SIGNATURE James Severy | | |

RECEIVED

JUN 24 1957

BUREAU V. 2

Continuation of an automobile in collision with another.

11

Continuation of an automobile in collision with another.

Continuation of an automobile in collision with another.

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Continuation of an automobile in collision with another.

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Continuation of an automobile in collision with another.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6668

CERTIFICATE OF DEATH

06664

Reg. Dist. No. 242

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| 1. PLACE OF DEATH a. COUNTY Prince Georges | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b 3 Days | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant | | d. STREET ADDRESS 700 65th Ave. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Lorenzo Middle D Last ace | | 4. DATE OF DEATH Month June Day 29 Year 19 57 | | 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Feb. 4, 94 | | 9. AGE (In years last birthday) 63 yrs. | | 10. IF UNDER 1 YEAR Months 29 Days 19 Hours 57 Min. | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber | | 10b. KIND OF BUSINESS OR INDUSTRY VA. | | 11. BIRTHPLACE (State or foreign country) VA. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Richard Pace | | 14. MOTHER'S MAIDEN NAME Minnie Bowen | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes <input checked="" type="checkbox"/> no <input type="checkbox"/> or unknown) YES | | 16. SOCIAL SECURITY NO. 700-65-2-101 | | | | | | | | | | | |
| 17. INFORMANT Mrs. Eliza P. Pace - 700-65-2-101 | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism 571.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ileitis DUE TO (c) 3 days | | INTERVAL BETWEEN ONSET AND DEATH 2 days | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month 19 Day 19 Hour a. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) Seat Pleasant | | (County) Prince Georges | | (State) Md. | | | |
| 21. I certify that I attended the deceased from 6/26 , 19 57 , to 6/29 , 19 57 , that I last saw the deceased alive on 6/29 , 19 57 , and that death occurred at 9:10 P.M. , from the causes and on the date stated above. | | 22. ADDRESS (Street, city or town, state) 2409 VARNUM ST. | | 23. DATE SIGNED 6/29/57 | | 24. ACTUAL SIGNATURE F. E. MUSSER | | 25. PHYSICIAN'S NAME (Type) F. E. MUSSER | | 26. ADDRESS LaVoy Hill, Md. | | 27. 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 27b. DATE THEREOF July 2, 1957 | | 27c. NAME OF CEMETERY OR CREMATORY Cedar Hill | | 27d. LOCATION (City, town or county) Seat Pleasant Md. | | 28. 24a. REC'D BY REGISTRAR Lee Funeral Home 40th + Mass Ave NW | | 24b. REGISTRAR'S SIGNATURE Edward F. Gillis | | DATE July 2-57 | |

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. H.

3 1957

RECEIVED

6669

CERTIFICATE OF DEATH

06665

Reg. Dist. No.

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|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince Georges County</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly,</u> | | | | c. LENGTH OF STAY IN 1b <u>7 hours</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Carl</u> Middle <u>E.</u> Last <u>Pearson</u> | | | | 4. DATE OF DEATH Month <u>June</u> Day <u>30</u> Year <u>1957</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>2-24-91</u> | |
| 9. AGE (In years last birthday) <u>66</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Federal Government</u> | | 11. BIRTHPLACE (State or foreign country) <u>Iowa</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u> | | | | | | | |
| 13. FATHER'S NAME <u>John S. Pearson</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Callie Mc Knight</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>W W I</u> | | | | 16. SOCIAL SECURITY NO. <u> </u> | | | |
| 17. INFORMANT <u>Carl E. Pearson Jr</u> | | | | Address <u>5207 Mineola Rd College Park, Md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary thrombosis myocardial infarction</u> DUE TO (c) <u> </u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>7 hrs</u> <u>8 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>June 30</u> , 19 <u>52</u> , to <u>June 30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 30</u> , 19 <u>57</u> , and that death occurred at <u>3:45</u> P. M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Hans Wodak</u> | | | | ADDRESS (Street, city or town, state) <u>30-c 4156E RD, GREENBELT, MD</u> DATE SIGNED <u>6-30-57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Dr. Hans Wodak</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>7/3/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u> | | 22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons Hyattsville, Maryland.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>JUL 2 '57</u> | | 24b. REGISTRAR'S SIGNATURE <u> </u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6670

CERTIFICATE OF DEATH

06666

Reg. Dist. No.

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|--|-------------------------------|--|---------------------------------------|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Prince George MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY Prince George | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandwine, Md. | | | |
| c. LENGTH OF STAY IN 1b 2 Days | | | | d. STREET ADDRESS Rt#1 Box 20 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Fannie Middle Pettus Last Pettus | | | | 4. DATE OF DEATH Month June Day 29 Year 57 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 19 1885 | | 9. AGE (In years lost birthday) 72 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY home | | 11. BIRTHPLACE (State or foreign country) N. C. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME unk. | | | | 14. MOTHER'S MAIDEN NAME unk. | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Mrs David Reifschneider Brandywine, Md | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Encephalopathy 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio Vascular Disease 10 years DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 days | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 6/27 1957 to 6/29 1957 , that I last saw the deceased alive on 6/29 1957 , and that death occurred at 7:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3503 Pennys ST DATE SIGNED 6/29/57 ACTUAL SIGNATURE Norman Donat Ameau M.D. PHYSICIAN'S NAME (Type) NORMAN DONAT AMEAU MT PAINIER MD | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 7-3-57 | | 22c. NAME OF CEMETERY OR CREMATORY Rock Hill Cem. | | 22d. LOCATION (City, town, or county) (State) Rock Hill, S. C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Huntt Funeral Home ADDRESS Waldorf, Md. | | | | 24a. REC'D BY REGISTRAR DATE | | 24b. REGISTRAR'S SIGNATURE W. L. Smith | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar's name to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 2 1957

RECEIVED

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

DATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06667

6706

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riggs Manor, Md | | c. LENGTH OF STAY IN 1b 2 years | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Riggs Manor, Md. | | d. STREET ADDRESS 2313 Woodberry Street | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2313 Woodberry Street,. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Lottie R. Middle Pfaff Last | | 4. DATE OF DEATH Month JUNE Day 12 Year 1957 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 11, 1871 |
| 9. AGE (In years last birthday) 86 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY own home | |
| 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME William E. Dixon | | 14. MOTHER'S MAIDEN NAME Olivia Griffith | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. no | |
| 17. INFORMANT Ethel Loux Riggs Manor, Md | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebrovascular hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) Generalized Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0 | | | INTERVAL BETWEEN ONSET AND DEATH 2-3 hrs. 10-15 yrs. |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Sept. 27, 1955, to JUNE 12, 1957, that I last saw the deceased alive on JUNE 5, 1957, and that death occurred at 8:30 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Robert B. Irey M.D. 7105 Riggs Rd. Hyattsville, Md 6/12/57 | | | |
| ACTUAL SIGNATURE Robert B. Irey | | PHYSICIAN'S NAME (Type) | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation 6/14/57 | | 22b. DATE THEREOF 6/14/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Philadelphia | | 22d. LOCATION (City, town, or county) (State) Pennsylvania | |
| 23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons | | ADDRESS Hyattsville, Maryland. | |
| 24a. REC'D BY REGISTRAR JUN 17 57 | | 24b. REGISTRAR'S SIGNATURE O. H. H. H. | |

JUN 17 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

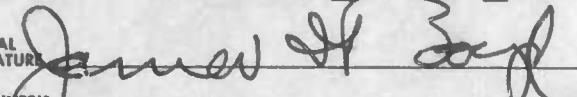

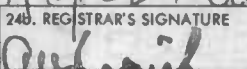
VS. A15ME(5)
5M 9/55

6671

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06668

Reg. Dist. No.

| | | | | | | | | | | | | | | | |
|--|--|---------------------------------------|--|---|--|---|--|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | | | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | | c. LENGTH OF STAY IN 1b Dead on arrival | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | | | e. STREET ADDRESS 5478 Spring Street | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Alfred Middle Frederick Last Pischke | | | | 4. DATE OF DEATH Month June Day 14 Year 19 57 | | | | | | | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH June 12, 1892 | | 9. AGE (In years last birthday) 65 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Warrant Officer | | | | 10b. BUSINESS OR INDUSTRY U. S. Navy | | | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | | | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | |
| 13. FATHER'S NAME August F. Pischke | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | | | 16. SOCIAL SECURITY NO. 26 years | | 17. INFORMANT Address Thomas E. Granishe, Forestville, Md. | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Acute congestive heart failure (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| | | | | | | | | | | | | | | | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE  EXAMINER'S NAME (Type) James I. Boyd | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> x | | | | DATE SIGNED June 14, 1957 | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF 6-18-1957 | | 22c. NAME OF CEMETERY OR CREMATORY Arlington Hotel | | | | 22d. LOCATION (City, town, or county) (State) 3x Myer, Va | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE  ADDRESS 1311-11 St Wash DC | | | | 24a. REC'D BY REGISTRAR June 17 57 | | 24b. REGISTRAR'S SIGNATURE  | | | | | | | | | |

RECEIVED

JUN 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06669

Reg. Dist. No.

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b D.O.A. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Mount Rainier | |
| 3. NAME OF DECEASED (Type or print) First Margaret Middle Anne Last Powell | | 4. DATE OF DEATH Month June Day 9, Year 19 57 | |
| 5. SEX Female | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH October 18, 1913 |
| 9. AGE (In years last birthday) 43 yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady | 10b. KIND OF BUSINESS OR INDUSTRY Women's Apparel |
| 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Leland Talbot | | 14. MOTHER'S MAIDEN NAME Charlotte Anne ? | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 577 344461 | |
| 17. INFORMANT Daniel Powell; same address | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial hemorrhage and shock DUE TO Fracture of base of skull Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall down stairs, hitting head on basement floor. | |
| 20c. TIME OF INJURY Month, Day, Year Hour 6:20 P.M. 6-9-57 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) a house | |
| 20f. (City or town) W. Lanham Hills. Pr. Geo. Md. (County) (State) | | 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | |
| ACTUAL SIGNATURE <i>John T. Maloney</i> EXAMINER'S NAME (Type) John T. Maloney, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12 June 1957 | |
| 22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery | | 22d. LOCATION (City, town, or county) (State) Arlington Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE F. GASCH'S SONS | | 24a. REC'D BY REGISTRAR June 13 57 | |
| ADDRESS Hyattsville, Md. | | 24b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar pay for burial, cremation, or removal.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: **Trine, Bertha**

AGE: **84.4** SEX: **Female**

DATE OF DEATH: **October 1, 1913**

PLACE OF DEATH: **Home**

Cause of Death: **Senile dementia; senile arteriosclerosis; senile pneumonia; senile bronchitis; senile diabetes; senile catarrh of bladder; senile prostatic hypertrophy; senile constipation; senile hemorrhoids; senile eczema; senile psoriasis; senile vitiligo; senile alopecia; senile leukoderma; senile ichthyosis; senile xerosis; senile pruritus; senile urticaria; senile angioedema; senile anaphylaxis; senile asthma; senile hay fever; senile eczema; senile psoriasis; senile vitiligo; senile alopecia; senile leukoderma; senile ichthyosis; senile xerosis; senile pruritus; senile urticaria; senile angioedema; senile anaphylaxis; senile asthma; senile hay fever;**

Signature of Medical Examiner: **Charles H. Jones**

Signature of Coroner: **John H. Jones**

Signature of Registrar: **John H. Jones**

Signature of Burial Officer: **John H. Jones**

Signature of Undertaker: **John H. Jones**

Signature of Physician: **John H. Jones**

Signature of Nurse: **John H. Jones**

Signature of Chaplain: **John H. Jones**

Signature of Minister: **John H. Jones**

Signature of Priest: **John H. Jones**

Signature of Rabbi: **John H. Jones**

Signature of Imam: **John H. Jones**

Signature of Minister of the Gospel: **John H. Jones**

RECEIVED
JUN 13 1957
BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6673

06670

Reg. Dist. No.

245

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale | | c. LENGTH OF STAY IN 1b 30 min. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ieland Memorial Hospital | | | | d. STREET ADDRESS Washington Tourists Court | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Joseph Maurice Power | | | | 4. DATE OF DEATH Month Day Year June 5, 19 57 | | | |
| 5. SEX Male | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 8. DATE OF BIRTH April , 1882 | | 9. AGE (In years last birthday) 75 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Musician | | 10b. KIND OF BUSINESS OR INDUSTRY Retired | | 11. BIRTHPLACE (State or foreign country) England | | | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 13. FATHER'S NAME Maurice Power | | | |
| 14. MOTHER'S MAIDEN NAME Unknown | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. 482-12-1232 | | 17. INFORMANT Address Joseph H. Manning, Soloman's, Maryland | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (b) (c) 442X | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 434.1 | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <i>John T. Maloney</i> EXAMINER'S NAME (Type) John T. Maloney, M.D. | | | | DATE SIGNED June 5, 1957 | | | |
| 22a. REMOVAL (Specify) Cremation | | 22b. DATE THEREOF 6-6-57 | | 22c. NAME OF CEMETERY OR CREMATORY Lees' Crematorium | | | |
| 22d. LOCATION (City, town, or county) (State) Washington, D.C. | | 23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home | | | | | |
| 24a. REC'D BY REGISTRAR JUN 7 1957 | | 24b. REGISTRAR'S SIGNATURE <i>James Deacy</i> | | | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|-------------------------------|--|------------------|--|
| Name of Deceased | | George Prince | |
| Sex | | Male | |
| Age | | 30 years | |
| Date of Death | | April 1, 1957 | |
| Place of Death | | Washington, D.C. | |
| Cause of Death | | Sudden death | |
| Manner of Death | | Natural | |
| Occupation | | Engineer | |
| Residence | | Washington, D.C. | |
| Signature of Medical Examiner | | [Signature] | |
| Signature of Coroner | | [Signature] | |

BUREAU V. 3

JUN 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6674

CERTIFICATE OF DEATH

Reg. Dist. No.

06671

| | | | | | | | |
|--|-------------------------------|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capitol Heights</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>36 Capitol Heights</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6107-- Bass street</u> | | | | d. STREET ADDRESS <u>6107-- Bass street</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>LUCILLE</u> Last <u>PRATHER</u> | | | | 4. DATE OF DEATH Month <u>June</u> Day <u>18</u> Year <u>1957</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>March 27, 1910</u> | 9. AGE (In years last birthday) <u>47</u> yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Indian Head, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>William Bowie</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Sarah Bowie</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>---</u> | | 17. INFORMANT <u>Nancy Prather - 6107 Bass, Capitol Heights</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | |
| | | | | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from <u>June 1, 1957</u> , to <u>June 18, 1957</u> , that I last saw the deceased alive on <u>June 18, 1957</u> , and that death occurred at <u>11:45</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>William Brainin</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>612 + Central Ave</u> DATE SIGNED <u>6/18/57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>WM BRAININ</u> | | | | Capitol Heights Md | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6-22-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Adair Hill Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Shutland, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chamber to</u> ADDRESS <u>517-11th St. S.E.</u> | | | | 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE <u>Lillian Campbell</u> | |

JUN 21 1957

CERTIFICATE OF DEATH

Form 10-57

1. Name of Deceased: *MARY ELIZABETH JAMES*
2. Sex: *F*
3. Age: *78*
4. Date of Birth: *1879*
5. Date of Death: *1957*
6. Place of Death: *Home*
7. Cause of Death: *Heart Disease*
8. Physician: *Dr. J. H. Smith*
9. Burial Place: *St. Mary's Cemetery*
10. Signature of Physician: *J. H. Smith*
11. Signature of Registrar: *J. H. Smith*
12. Signature of Coroner: *J. H. Smith*

BUREAU V. 3

JUN 21 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6707

06672

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Prince George</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Comodity Hills</u> | | c. LENGTH OF STAY IN TB <u>3 months</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Comodity Hills</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7507- Eads Street</u> | | | | d. STREET ADDRESS <u>7507- Eads Street</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Riley</u> Last <u>Pruitt</u> | | | | 4. DATE OF DEATH Month <u>June</u> Day <u>6</u> Year <u>1957</u> | | | |
| 5. SEX <u>male</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Dec 15 1881</u> | |
| 9. AGE (in years last birthday) <u>75</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Heating</u> | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>William Riley Pruitt</u> | | | | 14. MOTHER'S MARDEN NAME <u>Maria Moore</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u> </u> | | 17. INFORMANT <u>William L. Pruitt</u> Address <u>5316-Jaylark Bladenburg Md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute congestive heart failure</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cardiovascular renal disease</u> (c) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>James I. Boyd</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>June 6, 1957</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6/10/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Washington Natl.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Suitland Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers</u> ADDRESS <u>5801 Cleveland Ave. Riverdale Md</u> | | | | 24a. REC'D BY REGISTRAR <u> </u> DATE <u>7-10-57</u> | | 24b. REGISTRAR'S SIGNATURE <u> </u> | |

MEDICAL CERTIFICATION

WESTLAND STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUN 10 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6708

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06673

| | | | |
|---|------------------------|--|---------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville | | c. LENGTH OF STAY IN 1b 8 months | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5421 Pumphrey Drive | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Harry Middle Maurice Last Pumphrey | | 4. DATE OF DEATH Month June Day 15 Year 1957 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH August 8, 1889 |
| 9. AGE (In years (last birthday) yrs. 67 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Skilled laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Retired | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Enoch F. Pumphrey | | 14. MOTHER'S MAIDEN NAME Mary L. Hayes | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. Unknown | |
| 17. INFORMANT Address Same as # 2 | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion | | INTERVAL BETWEEN ONSET AND DEATH | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease | | | |
| (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 442X | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE James I. Boyd | | DATE SIGNED June 15, 1957 | |
| EXAMINER'S NAME (Type) James I. Boyd | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-18-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 22d. LOCATION (City, town, or county) (State) Suitland Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Jr. 517-11th St. S.E. | | 24. REC'D BY REGISTRAR DATE JUN 18 1957 | |
| | | 24b. REGISTRAR'S SIGNATURE | |

JUN 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06674

6675

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | | c. LENGTH OF STAY IN 1b 2 years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3507--56th Street | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First JOHN Middle K Last PUMPHREY | | | | 4. DATE OF DEATH Month June Day 25th Year 19 57 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 13th, 1876 | | 9. AGE (In years last birthday) yrs. 80 | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waiter | | 10b. KIND OF BUSINESS OR INDUSTRY Rsetaurant | | 11. BIRTHPLACE (State or foreign country) Oxon Hill, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Richard Pumphrey | | | | 14. MOTHER'S MAIDEN NAME (Unknown) Palmer | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 577-26-5593 | | 17. INFORMANT Address Helen Clay, 3507--56th St. Cheverly, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Semility DUE TO (c) Atherosclerosis | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 14yr 10yr 10yr |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 715X Respiratory ulcer over sacrum | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1 June , 1957, to 25 June , 1957, that I last saw the deceased alive on 23 June , 1957, and that death occurred at 4:00A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3404 Cheverly Ave., DATE SIGNED 6/25/57 ACTUAL SIGNATURE John Kehoe M.D. PHYSICIAN'S NAME (Type) JOHN KEHOE Cheverly, Md. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/29/1957 | | 22c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery | | 22d. LOCATION (City, town, or county) (State) Washington, D.C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md. | | | | 24a. REC'D BY REGISTRAR JUN 28 57 | | 24b. REGISTRAR'S SIGNATURE W. H. Leach | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar, to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11, 12 Film G216 6-10-57 et

6676

CERTIFICATE OF DEATH

06675

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesley c. LENGTH OF STAY IN lb 7 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last James E Queen | | 4. DATE OF DEATH Month Day Year June 2 1957 | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 22, 1913 |
| 9. AGE (In years last birthday) 44 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Gov't | |
| 11. BIRTHPLACE (State or foreign country) Seat Pleasant, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Harry Queen | | 14. MOTHER'S MAIDEN NAME Martha | |
| 15. WAS DECEASED IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Mary Queen | | Address 1647 West Virginia Ave., N.E. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 592 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic DUE TO Glomerulo-nephritis (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 5/27 , 19 57 , to 6/2 , 19 57 , that I last saw the deceased alive on 6/2 , 19 57 , and that death occurred at 4:10 P.M. , from the causes and on the date stated above. Max M. Herzberg ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE M.D. PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/8/1957 | |
| 22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet | | 22d. LOCATION (City, town, or county) (State) D.C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. T. Stewart | | 24a. REC'D BY REGISTRAR W. Smith | |
| ADDRESS 30 N. St. N.E. | | DATE JUN 7 57 | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

DATE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

AGE

SEX

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

TIME OF DEATH

PLACE OF DEATH

SEX

DATE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

TIME OF DEATH

PLACE OF DEATH

SEX

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

BUREAU V. R.

JUN 7 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06676

6709

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|------------------------------------|--|--|
| 1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews Air Force Base | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Forestville, Maryland x2 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1401st USAF Hospital, Andrews AFB | | d. STREET ADDRESS 3314 Lorrington Drive | |
| 3. NAME OF DECEASED (Type or print) First Mary Middle Ann Last Rable | | 4. DATE OF DEATH Month June Day 27 Year 1957 | |
| 5. SEX Female | 6. COLOR OR RACE Cau | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 28 November 1954 |
| 9. AGE (In years lost birthday) yrs. 2 | | 10. CITIZEN OF WHAT COUNTRY? United States | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not Applicable | | 10b. KIND OF BUSINESS OR INDUSTRY Not Applicable | |
| 11. BIRTHPLACE (State or foreign country) Bolling AF Base Hospital Bolling AFB, Wash 25, D.C. | | 12. CITIZEN OF WHAT COUNTRY? United States | |
| 13. FATHER'S NAME Frank P. Rable | | 14. MOTHER'S MAIDEN NAME Catherine Ruth Bly | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Not Applicable | | 16. SOCIAL SECURITY NO. Not Applicable | |
| 17. INFORMANT Address Frank P. Rable (Father) 3314 Lorrington Drive North Forestville, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 903.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) Cellulitis, left leg (c) Abrasion, left knee 3 Days 6 Days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 570.1 Paralytic ileus | | | INTERVAL BETWEEN ONSET AND DEATH 2 Days 3 Days 6 Days |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Innocent Fall | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Innocent Fall | |
| 20c. TIME OF INJURY Month, Day, Year Hour 1:30 p. m. June 21 1957 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street | | 20f. (City or town) N. Forestville Prince Georges, Maryland | |
| 21. I certify that I attended the deceased from 26 June 1957, to 27 June 1957, that I last saw the deceased alive on 27 June 1957, and that death occurred at 8:30 PM, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Charles L. Picus | | DATE SIGNED 27 June 57 | |
| PHYSICIAN'S NAME (Type) CHARLES L. PICUS, Captain, USAF (MC) | | ADDRESS (Street, city or town, state) Andrews AFB, Washington 25, D.C. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF June 29, 1957 | 22c. NAME OF CEMETERY OR CREMATORY Wilkes-Barre, Penna. | 22d. LOCATION (City, town, or county) (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Luccas | | 24a. REC'D BY REGISTRAR DATE Jul 5 '57 | |
| ADDRESS 1756 Pa. Washington, DC. | | 24b. REGISTRAR'S SIGNATURE W. L. Luccas | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | |
|------------------|--|----------------|--|-----------------|--|---------------------|--|------------------------|--|----------------|--|----------------|--|-----------------|--|---------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY OF BIRTH | | STATE OF BIRTH | | COUNTRY OF BIRTH | |
| JAMES EARL RAY | | 35 | | M | | W | | 1928 | | MEMPHIS | | TENNESSEE | | UNITED STATES | | UNITED STATES | |
| DATE OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | | STATE OF DEATH | | COUNTRY OF DEATH | | DATE OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | | STATE OF DEATH | |
| APRIL 4, 1968 | | MEMPHIS | | MEMPHIS | | TENNESSEE | | UNITED STATES | | APRIL 4, 1968 | | MEMPHIS | | MEMPHIS | | TENNESSEE | |
| TIME OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | | DISEASE OR INJURY | | ORGAN OR PART AFFECTED | | TIME OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | | DISEASE OR INJURY | |
| 10:00 PM | | HEART DISEASE | | SUICIDE | | CORONARY THROMBOSIS | | HEART | | 10:00 PM | | HEART DISEASE | | SUICIDE | | CORONARY THROMBOSIS | |
| PLACE OF DEATH | | CITY OF DEATH | | STATE OF DEATH | | COUNTRY OF DEATH | | DATE OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | | STATE OF DEATH | | COUNTRY OF DEATH | |
| MEMPHIS | | MEMPHIS | | TENNESSEE | | UNITED STATES | | APRIL 4, 1968 | | MEMPHIS | | MEMPHIS | | TENNESSEE | | UNITED STATES | |
| DATE OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | | STATE OF DEATH | | COUNTRY OF DEATH | | DATE OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | | STATE OF DEATH | |
| APRIL 4, 1968 | | MEMPHIS | | MEMPHIS | | TENNESSEE | | UNITED STATES | | APRIL 4, 1968 | | MEMPHIS | | MEMPHIS | | TENNESSEE | |
| TIME OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | | DISEASE OR INJURY | | ORGAN OR PART AFFECTED | | TIME OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | | DISEASE OR INJURY | |
| 10:00 PM | | HEART DISEASE | | SUICIDE | | CORONARY THROMBOSIS | | HEART | | 10:00 PM | | HEART DISEASE | | SUICIDE | | CORONARY THROMBOSIS | |

BURIAL Y. E.

JUL 5 1967

RECEIVED

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6677

CERTIFICATE OF DEATH

06677

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|--|--|---|---|---|--|
| 1. PLACE OF DEATH o. COUNTY Pr. Geo's. MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo's. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | c. LENGTH OF STAY IN 1b 2 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/ Naylor, | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pr. Geo's. General Hospital | | | | d. STREET ADDRESS ---- | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First James Middle Wilson Last Rawlings | | | 4. DATE OF DEATH Month June Day 24, Year 19 57 | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 10, 1897 | | 9. AGE (In years last birthday) 60 yrs. | IF UNDER 1 YEAR Months 3 Days 24 Hours 57 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocery Business | | 10b. KIND OF BUSINESS OR INDUSTRY Own Store | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME James William Rawlings | | | 14. MOTHER'S MAIDEN NAME Bessie W. Perrie | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. ---- | | 17. INFORMANT Rawlings Address Mrs. Grace Wix Naylor, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Right Lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) with metastases to Liver DUE TO (c) Arteriosclerosis | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4500 | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---- | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---- | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Mar 3, 19 57 to June 24, 19 57 , that I last saw the deceased alive on June 24, 19 57 , and that death occurred at 1:20 M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE James G. Sasscer M.D. | | DATE SIGNED Upper Marlboro - Md. 6-24-57 | | | | | |
| PHYSICIAN'S NAME (Type) James G. Sasscer, M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/26/57 | | 22c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery | | 22d. LOCATION (City, town, or county) (State) Baden Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Upper Marlboro, Md. | | | | 24a. REC'D BY REGISTRAR DATE JUN 28 57 | | 24b. REGISTRAR'S SIGNATURE Overhach | |

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BUREAU V. S.

JUN 28 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for a burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G217 6-24-57 et

CERTIFICATE OF DEATH

06678

6678

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly Md</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, Md.</u> | | | |
| c. LENGTH OF STAY IN 1b <u>DOA</u> | | | | d. STREET ADDRESS <u>4110 Emerson Street</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>Rea</u> Last <u>Rea</u> | | | | 4. DATE OF DEATH Month <u>June</u> Day <u>12</u> Year <u>1957</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>June 6, 1880</u> | |
| 9. AGE (In years last birthday) <u>77</u> yrs. | | IF UNDER 1 YEAR Months <u>12</u> Days <u>19</u> Hours <u>57</u> Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Grsnite Works</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Washington D. C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u> | | 13. FATHER'S NAME <u>William Rea</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>Henry Rea</u> | | 17. INFORMANT <u>(Son)</u> | | Address <u>Hyattsville, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 coronary occlusion</u> DUE TO <u>anterior chest heart area</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>years</u> DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>March</u> , 19 <u>57</u> , to <u>June</u> , 19 <u>57</u> that I last saw the deceased alive on <u>June 12</u> , 19 <u>57</u> , and that death occurred at <u>12:55 AM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Hyattsville Md</u> DATE SIGNED <u>6/12/57</u> | | | | | | | |
| ACTUAL SIGNATURE <u>V. E. Rea</u> M.D. | | | | PHYSICIAN'S NAME (Type) <u>Hyattsville Md</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6/14/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Maryland.</u> | | | | 24a. REC'D BY REGISTRAR <u>June 17 '57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Alb. Leach</u> | |

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

For use in

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| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. RACE | | 5. DATE OF BIRTH | | 6. PLACE OF BIRTH | | 7. DATE OF DEATH | | 8. PLACE OF DEATH | | 9. CAUSE OF DEATH | | 10. MANNER OF DEATH | | 11. SIGNATURE OF REGISTRAR | | 12. SIGNATURE OF PHYSICIAN | | 13. SIGNATURE OF FUNERAL HOME | | 14. SIGNATURE OF WITNESSES | | 15. SIGNATURE OF CORONER | | 16. SIGNATURE OF JURY | | 17. SIGNATURE OF JUDGE | | 18. SIGNATURE OF CLERK | | 19. SIGNATURE OF NOTARY | | 20. SIGNATURE OF OTHER OFFICIALS | |
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6679

CERTIFICATE OF DEATH

06679

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH o. COUNTY PRINCE GEORGES MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY PRINCE GEORGES | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY | | | | c. LENGTH OF STAY IN 1b 2 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGES GEN. HOSP. | | | | e. STREET ADDRESS 17529 Central Avenue | | | |
| 3. NAME OF DECEASED (Type or print) First JOHN L. Middle REDMILES Last REDMILES | | | | 4. DATE OF DEATH Month JUNE Day 8 Year 1957 | | | |
| 5. SEX MALE | | 6. COLOR OR RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1-23-86 | |
| 9. AGE (In years last birthday) 71 yrs. | | IF UNDER 1 YEAR Months 7 Days 1 Hours 15 Min. | | IF UNDER 24 HRS. Months 7 Days 1 Hours 15 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Empl'd. Electrician Transit Co. | | | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | | | |
| 11. BIRTHPLACE (State or foreign country) U. S. A. | | | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | |
| 13. FATHER'S NAME Lemuel Redmiles | | | | 14. MOTHER'S MAIDEN NAME Mary Ann Shoemaker | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk. | | | | 16. SOCIAL SECURITY NO. --- | | | |
| 17. INFORMANT Mrs. Lillie E. Hampton-Seat Pleasant, Md. | | | | Address 7529 Central Ave. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 150X DUE TO Ca of Emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hemorrhage DUE TO Cardiac Failure (c) Cardiac Failure | | | | INTERVAL BETWEEN ONSET AND DEATH unknown | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 6/8 , 19 57 , to 6/8 , 19 57 , that I last saw the deceased alive on 6/8 , 19 57 , and that death occurred at 5:50 A. M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Max M. Herzberg | | | | ADDRESS (Street, city or town, state) Prince Geo's Gen. Hospital, Cheverly, Md. | | | |
| DATE SIGNED 6/8/57 | | | | | | | |
| PHYSICIAN'S NAME (Type) MAX M. HERZBERG | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/11/57 | | 22c. NAME OF CEMETERY OR CREMATORY Trinity Cemetery | | 22d. LOCATION (City, town, or county) (State) Patuxant Station Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home | | | | ADDRESS Upper Marlboro, Md. | | | |
| 24a. REC'D BY REGISTRAR 12 '57 | | | | 24b. REGISTRAR'S SIGNATURE Rehail | | | |

JUN 12 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6680

CERTIFICATE OF DEATH

06680

Reg. Dist. No.

| | | | |
|--|---------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Prince George MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Pg/ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md | | c. LENGTH OF STAY IN 1b 2 Days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Woodlawn, Md | |
| 3. NAME OF DECEASED (Type or print) Stephen Joseph First Baby Boy Middle Reilly Last | | 4. DATE OF DEATH Month June Day 27 Year 19 57 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6-25-57 |
| 9. AGE (In years, low birth days, yrs.) 2 1/2 | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | 11. BIRTHPLACE (State or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY? U S A | | 13. FATHER'S NAME James F. Reilly | |
| 14. MOTHER'S MAIDEN NAME Margaret H. Hawes | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No | |
| 16. SOCIAL SECURITY NO. None | | 17. INFORMANT James F. Reilly Same as # 2 Father | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 560.4 DUE TO Bilateral Atrial Fibrillation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary embolism DUE TO left to right shunt (c) left to right shunt | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 762.0 | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 19 to 19, that I last saw the deceased alive on 19 and that death occurred at 3:00 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE Albert Roth | | M.D. Riverdale, Md 6/27/57 | |
| PHYSICIAN'S NAME (Type) Albert Roth | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/28/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | | 22d. LOCATION (City, town, or county) (State) Washington, D. C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland | | 24a. REC'D BY REGISTRAR DATE JUL 3 '57 | |
| | | 24b. REGISTRAR'S SIGNATURE | |

2077263XV3

CERTIFICATE OF DEATH

BUREAU V. 2

1957 3 17

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar's name, a burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06681 *442*

6710

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|---|---|---|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairmont Heights</u> | | | c. LENGTH OF STAY IN 1b <u>x2</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairmont Heights</u> | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>613 60th Place</u> | | | | d. STREET ADDRESS <u>613 60th Place</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Nancy J. Roberts</u> | | | | 4. DATE OF DEATH Month Day Year <u>June 4, 1957</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Colored</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8/3/1874</u> | 9. AGE (In years last birthday) yrs. <u>82</u> | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Samuel Corbin</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary E. Sinclair</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Charles Roberts, Jr.</u> Address <u>613 60th Pl., Fairmont Hts., Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerosis - Heart Disease</u> <u>420.0</u> DUE TO <u>Pulmonary Congestion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteritis</u> (c) <u>Arteritis</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>12 yrs.</u> <u>4 days</u> <u>7 yrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteritis 72.5X</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Hour a. ft. p. m. | Month, Day, Year 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | |
| 21. I certify that I attended the deceased from <u>Jan. 10th</u> , 19 <u>57</u> , to <u>June 4th</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 4th</u> , 19 <u>57</u> , and that death occurred at <u>316</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>W. H. Broce</u> | | | ADDRESS (Street, city or town, state) <u>3847 - Mount Airy N.C.</u> | | DATE SIGNED <u>6-4-57</u> | | |
| PHYSICIAN'S NAME (Type) <u>W. H. BROCE, MD</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>6/9/1957</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Alexandria, Virginia</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. M. Jones</u> | | | ADDRESS <u>1820 9th S., N.W.</u> | | 24a. REC'D BY REGISTRAR DATE <u>JUN 10 1957</u> | 24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u> | |

CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. NAME OF DECEASED [Illegible] | | 2. SEX [Illegible] | | 3. AGE [Illegible] | | 4. DATE OF BIRTH [Illegible] | |
| 5. PLACE OF BIRTH [Illegible] | | 6. OCCUPATION [Illegible] | | 7. MARITAL STATUS [Illegible] | | 8. COLOR [Illegible] | |
| 9. DATE OF DEATH [Illegible] | | 10. TIME OF DEATH [Illegible] | | 11. PLACE OF DEATH [Illegible] | | 12. CAUSE OF DEATH [Illegible] | |
| 13. MEDICAL HISTORY [Illegible] | | 14. PRESENT ILLNESS [Illegible] | | 15. TREATMENT [Illegible] | | 16. SIGNATURE OF PHYSICIAN [Illegible] | |
| 17. SIGNATURE OF REGISTRAR [Illegible] | | 18. SIGNATURE OF WITNESS [Illegible] | | 19. SIGNATURE OF DECEASED [Illegible] | | 20. SIGNATURE OF NEXT OF KIN [Illegible] | |

RECEIVED
JUN 10 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar's name, date of burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | |
|---|--|---------------------------|---|--|---|-----------------------------|--|---|--|
| 6681 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| Reg. Dist. No. 07800 | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Prince George MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Pg. | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md | | | c. LENGTH OF STAY IN 1b 7 Hrs. 45 Min | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cottage City | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General | | | | | d. STREET ADDRESS 3705 41st. Ave. | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Baby Boy Robertson | | | | | 4. DATE OF DEATH Month Day Year June 28 1957 | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 6-27-57 | | 9. AGE (In years last birthday) 7 hrs 15 min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Md. | | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Horace Clifford Robertson | | | | | 14. MOTHER'S MAIDEN NAME Marie Alice Lysikovski | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Marie (Mother) | | | Address Same As above | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) Atelectasis Prematurity INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from 6/27, 1957, to 6/28, 1957, that I last saw the deceased alive on 6/28, 1957, and that death occurred at 3:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 5301 Hamilton St., Hyattsville 6/28/57 | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | 22b. DATE THEREOF July 1957 | | 22c. NAME OF CEMETERY OR CREMATORY Prince Georges In Hosp | | 22d. LOCATION (City, town, or county) (State) Cheverly Md |
| 23. FUNERAL DIRECTOR'S SIGNATURE Henry M. Ramo | | | | | ADDRESS Arden | | 24a. REC'D BY REGISTRAR DATE JUL 20 '57 | | 24b. REGISTRAR'S SIGNATURE A. Smith |

2077264XVO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

BUREAU 7

RECEIVED

107 22 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

1

6711

Items 1,2,9 Film 6217 7-5-57 et

06682

234

Reg. Dist. No.

6711

Items 1,2,9 Film 6217 7-5-57 et

CERTIFICATE OF DEATH

| | | | | | | | |
|--|----------------------------|---|---------------------------------------|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Private home</u> | | | | d. STREET ADDRESS <u>16819 Mary Hill Drive</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>NEWTON C. ROBISON</u> | | | | 4. DATE OF DEATH <u>JUNE 28</u> Year <u>1957</u> | | | |
| 5. SEX <u>M.</u> | 6. COLOR OR RACE <u>W.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec. 31, 1874</u> | 9. AGE (In years last birthday) <u>82 1/2</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Artist</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Illinois</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Newton C. Robinson</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Snider</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>333-10-5501</u> | | 17. INFORMANT <u>Loran J. Robinson</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRO-VASCULAR ACCIDENT</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u>years</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>April</u> , 19 <u>56</u> to <u>June</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 28</u> , 19 <u>57</u> , and that death occurred at <u>5:30</u> M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Robert Wisotsky</u> | | M.D. <u>10/Andrew Lane</u> | | DATE SIGNED <u>6/28/57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>11 ROBERT WISOTSKY MD</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 22b. DATE THEREOF <u>6/28/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) <u>Marion, Illinois</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Samuelson</u> ADDRESS <u>741-11 St. St. Chicago A. Walsh 495</u> | | | | 24a. REC'D BY REGISTRAR <u>Carrie Campbell</u> | | 24b. REGISTRAR'S SIGNATURE | |

JUL 1 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU V. S.

JUL 1 1957

RECEIVED

6712

CERTIFICATE OF DEATH

06683

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews Air Force Base | | | | c. LENGTH OF STAY IN 1b 1 Yr. 10 mo. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bldg T-3-232 - Base Area | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last EDMUND HENRY ROSENTHAL | | | | 4. DATE OF DEATH Month Day Year June 10 19 57 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Oau | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH April 4, 1920 | |
| 9. AGE (In years last birthday) 37 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pilot | | | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Air Force | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | |
| 12. CITIZEN OF WHAT COUNTRY? United States | | | | | | | |
| 13. FATHER'S NAME Edmund Rosenthal | | | | 14. MOTHER'S MAIDEN NAME Natalie Conrad | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | | | 16. SOCIAL SECURITY NO. (If yes, give war or naval service) 3 MII Reverse 165-14-3415 | | 17. INFORMANT Personnel Records M/SCT THOMAS R. TRVIN | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbonmonoxide Poisoning 979.3 DUE TO Suicide Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c) | | | | INTERVAL BETWEEN ONSET AND DEATH unknown | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from 13 June 19 57, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. See Reverse Side ACTUAL SIGNATURE <i>Charles W. De Baun</i> M.D. ADDRESS (Street, city or town, state) DATE SIGNED 1401st USAF Hospital 13 June 1957 Andrews Air Force Base Washington 25, D. C. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 22b. DATE THEREOF 18 June 1957 | | 22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery | |
| 22d. LOCATION (City, town, or county) (State) Arlington, Virginia | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Jr. 517-11 #1 S.E. | | | | 24a. REC'D BY REGISTRAR DATE JUN 18 57 | | 24b. REGISTRAR'S SIGNATURE Paul | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SERVICE DATA WW II

5 May 1941 to 20 March 1946
21 March 1946 to 16 December 1948
17 December 1948 to present

Active Service
Inactive Service
Active Service USAF

Item 21: I certify that I attended the deceased on 13 June 1957, this after being summoned to scene of death by USAF authorities, Andrews Air Force Base, Washington 25, D. C., Upon my arrival at the scene I confirmed death. Time of death could not be determined by my examination, however, the gross appearance of the body was one of at least a 2 or 3 day duration. I arrived at scene of death at 4:00 P.M., June 13, 1957.

Charles W. De Baun

CHARLES W. DE BAUN, Colonel USAF (MC) 1401st USAF Hospital
Andrews Air Force Base
Washington 25, D. C.

BUREAU V. S.

JUN 18 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

6713

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06684

Reg. Dist. No.

| | | | |
|---|-------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leesbrook Heights</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leesbrook Heights</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7102 Foster Street</u> | | d. STREET ADDRESS <u>7102-Foster Street</u> | |
| 3. NAME OF DECEASED (Type or print) <u>(HORRIS) Horace Edgar Rush</u> | | 4. DATE OF DEATH Month <u>June</u> Day <u>7</u> Year <u>1957</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb 13, 1897</u> |
| 9. AGE (In years last birthday) <u>60</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>60</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Book Keeper</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Missouri</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u> | |
| 13. FATHER'S NAME <u>Harace Rush</u> | | 14. MOTHER'S MAIDEN NAME <u>Holly Jane Anderson</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WWI</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | |
| 17. INFORMANT <u>Nancy Mitchell</u> | | Address <u>same as #2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) _____ | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4341</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. <u>0</u> p. m. <u>0</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>James I. Boyd</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>JAMES I. Boyd</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6-10-57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u> | | 22d. LOCATION (City, town or county) (State) <u>Suitland, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co. Washington, D.C.</u> | | 24a. REC'D BY REGISTRAR <u>June 12 '57</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>W. W. Chambers</u> | |

MASSACHUSETTS STATE DEPARTMENT OF HEALTH-BALLOON 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

[Faint, mostly illegible text from the medical certificate form, including fields for name, date, and cause of death.]

BUREAU V. 3

JUN 12 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6618

CERTIFICATE OF DEATH

06685

Reg. Dist. No.

| | | | | | | | |
|--|------------------------|--|---|---|--|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4708-31st Place | | | | d. STREET ADDRESS 14708-31st Place | | | |
| 3. NAME OF DECEASED (Type or print) James First Michael Middle Ryan Last | | | | 4. DATE OF DEATH June 8th 1957 | | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7/28/1902 | 9. AGE (In years last birthday) 54 yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Southern Railway Auditor, Ret. | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Philadelphia, Pa. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A | |
| 13. FATHER'S NAME James Joseph Ryan | | | | 14. MOTHER'S MAIDEN NAME Catherine Gilligan | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Amy Margaret Ryan (Wife) | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Amyotrophic Lateral Sclerosis 356.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from June 1957, 19, to June 8, 1957, that I last saw the deceased alive on June 3, 1957, and that death occurred at 4:30a M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Ronald S. Fleischer (M.D.) | | | | ADDRESS (Street, city or town, state) DATE SIGNED 5432 QUEENS CHAPEL Rd Hyattsville, Md 6/8/57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| Burial | | 6-11-1957 | | Mt. Olivet | | Washington, D.C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Address | | | | 24a. REC'D BY REGISTRAR DATE | | 24b. REGISTRAR'S SIGNATURE | |
| Pelley's Funeral Home, Mt. Rainier, Inc., Md. | | | | JUN 11 1957 | | James Seaver | |

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

PREVIOUS ILLNESS

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

BUREAU V. 3

JUN 11 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
5M 5/55

6682 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06686

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Rainier | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital | | | | d. STREET ADDRESS 4307 Russell Avenue | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First George Middle Rudolph Last Schuetzler | | | | 4. DATE OF DEATH Month June Day 15 Year 1957 | | | |
| 5. SEX Male | | 6. COLOR OR RACE white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH October 10, '02 | |
| 9. AGE (In years last birthday) 54 yrs. | | IF UNDER 1 YEAR Months 54 Days 54 Hours 54 Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic | | | | 10b. KIND OF BUSINESS OR INDUSTRY Instrument maker | | 11. BIRTHPLACE (State or foreign country) Germany | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Rudolph Schuetzler | | | | 14. MOTHER'S MAIDEN NAME Clara Boehmelte | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. 107-09-6694 | | | |
| 17. INFORMANT Rudolph G. Schuetzler; Hyattsville, Md. | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442 x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour 19 a. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE John T. Maloney M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) John T. Maloney, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 15, 1957 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/19/57 | | 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill | | 22d. LOCATION (City, town, or county) (State) Suitland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. | | | | 24. REC'D BY REGISTRAR 5801 Cleveland Ave Riverdale, Md. JUN 18 '57 | | | |
| 25. REGISTRAR'S SIGNATURE | | | | | | | |

BUREAU

JUN 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6616

CERTIFICATE OF DEATH

Reg. Dist. No.

06687 245

| | | | | | | | |
|---|------------------------------|--|--|---|--|--|--|
| 1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGE'S CO</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>VIRGINIA</u> b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. HYATTSVILLE</u> | | c. LENGTH OF STAY IN 1b <u>2yrs 3mos 10da</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARLINGTON - 7 VA. 83X-3</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MS S BELL'S NURSING HOME FOR CHILDREN</u> | | | | d. STREET ADDRESS <u>3134 N. THOMAS ST.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Cheryl</u> Middle <u>Ann</u> Last <u>Scotfield</u> | | | | 4. DATE OF DEATH Month <u>JUNE</u> Day <u>9</u> Year <u>1957</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>JULY 22-1954</u> | | 9. AGE (In years last birthday) yrs. <u>2</u> Months <u>10</u> Days <u>18</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | 11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>William H. Scotfield</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Josephine Oakley</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> <u>325.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertension</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>422.2</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>6/9</u> , 19 <u>57</u> , and that death occurred at _____ M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Thomas A. Christensen</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>College Park, Md</u> | | DATE SIGNED <u>6/8/57</u> | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF <u>Shipping date June 10, 1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Indian Mound Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Moravian N. Y.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Eves Funeral Home</u> <u>C. M. Evans</u> | | | | ADDRESS <u>2847 Wilson Blvd, Cal. Va</u> | | 24a. REC'D BY REGISTRAR <u>6-57</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Amos G. Bevere</u> | | | |

BUREAU V. S.

JUN 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film 6217 6-24-57 et

6683

CERTIFICATE OF DEATH

06688

Reg.-Dist. No.

| | | | | | | | |
|---|----------------------------------|--|---|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>25 Riverdale</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Private home - Item #2.</u> | | | | d. STREET ADDRESS <u>6011-TAYLOR ROAD, RIVERDALE</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>BRIDGET AGNES SHARKEY</u> | | | | 4. DATE OF DEATH Month Day Year <u>JUNE 13 1957</u> | | | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>MARCH 14, 1876</u> | 9. AGE (In years last birthday) <u>81</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | 11. BIRTHPLACE (State or foreign country) <u>ENGLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME <u>OWEN SHARKEY</u> | | | | 14. MOTHER'S MAIDEN NAME <u>BRIDGET DWYER</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> | | 16. SOCIAL SECURITY NO. <u>165-09-2483A</u> | | 17. INFORMANT Address <u>THOMAS KANE 6011-TAYLOR ROAD</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Vascular Accident, Hypertension</u> DUE TO (c) <u>Arteriosclerotic Cerebral Vascular Disease</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>2 weeks</u> <u>—</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>331X</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Feb</u> , 1954, to <u>June 13</u> , 1957, that I last saw the deceased alive on <u>June 1st</u> , 1957, and that death occurred at <u>10:20 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Gordon W. Kelley M.D. 6124-46th Ave. Hyattsville Md 6/14/57</u> | | | | | | | |
| ACTUAL SIGNATURE <u>Gordon W. Kelley</u> | | | | PHYSICIAN'S NAME (Type) <u>Gordon W. Kelley</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>JUNE 18 1957 HOLY SEPULCHER</u> | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) <u>PHILADELPHIA, PA</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>P. J. Saffell</u> | | | | 24a. REC'D BY REGISTRAR <u>475-H 7th St N.W. Wash D.C.</u> | | 24b. REGISTRAR'S SIGNATURE <u>James D. ...</u> | |

CERTIFICATE OF DEATH

Form 10-57-1

| | | | | | |
|------------------------------------|--|----------------------------------|--|---|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | |
| 4. RACE | | 5. DATE OF BIRTH | | 6. PLACE OF BIRTH | |
| 7. DATE OF DEATH | | 8. PLACE OF DEATH | | 9. CAUSE OF DEATH | |
| 10. MANNER OF DEATH | | 11. SIGNATURE OF PHYSICIAN | | 12. SIGNATURE OF REGISTRAR | |
| 13. SIGNATURE OF WITNESS | | 14. SIGNATURE OF DECEASED | | 15. SIGNATURE OF NEXT OF KIN | |
| 16. SIGNATURE OF CLERGYMAN | | 17. SIGNATURE OF BURIAL OFFICIAL | | 18. SIGNATURE OF FUNERAL HOME | |
| 19. SIGNATURE OF CORONER | | 20. SIGNATURE OF JURY | | 21. SIGNATURE OF JUDGE | |
| 22. SIGNATURE OF DISTRICT ATTORNEY | | 23. SIGNATURE OF SHERIFF | | 24. SIGNATURE OF CLERK | |
| 25. SIGNATURE OF CHIEF OF POLICE | | 26. SIGNATURE OF TOWNSHIP CLERK | | 27. SIGNATURE OF COUNTY CLERK | |
| 28. SIGNATURE OF STATE CLERK | | 29. SIGNATURE OF FEDERAL CLERK | | 30. SIGNATURE OF POSTAL CLERK | |
| 31. SIGNATURE OF MARSHAL | | 32. SIGNATURE OF JAILER | | 33. SIGNATURE OF PRISONER | |
| 34. SIGNATURE OF WARDEN | | 35. SIGNATURE OF CHIEF OF PRISON | | 36. SIGNATURE OF DEPUTY CHIEF OF PRISON | |
| 37. SIGNATURE OF CHIEF OF POLICE | | 38. SIGNATURE OF TOWNSHIP CLERK | | 39. SIGNATURE OF COUNTY CLERK | |
| 40. SIGNATURE OF STATE CLERK | | 41. SIGNATURE OF FEDERAL CLERK | | 42. SIGNATURE OF POSTAL CLERK | |
| 43. SIGNATURE OF MARSHAL | | 44. SIGNATURE OF JAILER | | 45. SIGNATURE OF PRISONER | |
| 46. SIGNATURE OF WARDEN | | 47. SIGNATURE OF CHIEF OF PRISON | | 48. SIGNATURE OF DEPUTY CHIEF OF PRISON | |
| 49. SIGNATURE OF CHIEF OF POLICE | | 50. SIGNATURE OF TOWNSHIP CLERK | | 51. SIGNATURE OF COUNTY CLERK | |
| 52. SIGNATURE OF STATE CLERK | | 53. SIGNATURE OF FEDERAL CLERK | | 54. SIGNATURE OF POSTAL CLERK | |
| 55. SIGNATURE OF MARSHAL | | 56. SIGNATURE OF JAILER | | 57. SIGNATURE OF PRISONER | |
| 58. SIGNATURE OF WARDEN | | 59. SIGNATURE OF CHIEF OF PRISON | | 60. SIGNATURE OF DEPUTY CHIEF OF PRISON | |
| 61. SIGNATURE OF CHIEF OF POLICE | | 62. SIGNATURE OF TOWNSHIP CLERK | | 63. SIGNATURE OF COUNTY CLERK | |
| 64. SIGNATURE OF STATE CLERK | | 65. SIGNATURE OF FEDERAL CLERK | | 66. SIGNATURE OF POSTAL CLERK | |
| 67. SIGNATURE OF MARSHAL | | 68. SIGNATURE OF JAILER | | 69. SIGNATURE OF PRISONER | |
| 70. SIGNATURE OF WARDEN | | 71. SIGNATURE OF CHIEF OF PRISON | | 72. SIGNATURE OF DEPUTY CHIEF OF PRISON | |
| 73. SIGNATURE OF CHIEF OF POLICE | | 74. SIGNATURE OF TOWNSHIP CLERK | | 75. SIGNATURE OF COUNTY CLERK | |
| 76. SIGNATURE OF STATE CLERK | | 77. SIGNATURE OF FEDERAL CLERK | | 78. SIGNATURE OF POSTAL CLERK | |
| 79. SIGNATURE OF MARSHAL | | 80. SIGNATURE OF JAILER | | 81. SIGNATURE OF PRISONER | |
| 82. SIGNATURE OF WARDEN | | 83. SIGNATURE OF CHIEF OF PRISON | | 84. SIGNATURE OF DEPUTY CHIEF OF PRISON | |
| 85. SIGNATURE OF CHIEF OF POLICE | | 86. SIGNATURE OF TOWNSHIP CLERK | | 87. SIGNATURE OF COUNTY CLERK | |
| 88. SIGNATURE OF STATE CLERK | | 89. SIGNATURE OF FEDERAL CLERK | | 90. SIGNATURE OF POSTAL CLERK | |
| 91. SIGNATURE OF MARSHAL | | 92. SIGNATURE OF JAILER | | 93. SIGNATURE OF PRISONER | |
| 94. SIGNATURE OF WARDEN | | 95. SIGNATURE OF CHIEF OF PRISON | | 96. SIGNATURE OF DEPUTY CHIEF OF PRISON | |
| 97. SIGNATURE OF CHIEF OF POLICE | | 98. SIGNATURE OF TOWNSHIP CLERK | | 99. SIGNATURE OF COUNTY CLERK | |
| 100. SIGNATURE OF STATE CLERK | | 101. SIGNATURE OF FEDERAL CLERK | | 102. SIGNATURE OF POSTAL CLERK | |

RECEIVED
JUN 17 1957
BUREAU V. S.

6714

CERTIFICATE OF DEATH

06689

Reg. Dist. No. 242

| | | | | | | | |
|--|-------------------------------|--|---------------------------------|--|-----------------|--|---|
| 1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Va</u> b. COUNTY <u>Northampton</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Seat Pleasant</u> c. LENGTH OF STAY IN b <u>6 mos</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cape Charles</u> <u>83 X 30</u> ✓ | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u> | | | | d. STREET ADDRESS <u>Washington Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Racheal</u> First Middle Last <u>Smith</u> | | | | f. DATE OF DEATH <u>June</u> Month <u>1</u> Day <u>1957</u> Year | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Unknown</u> | 9. AGE (In years last birthday) <u>81</u> yrs. | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | 11. BIRTHPLACE (State or foreign country) <u>W. Virginia</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Calvin Smith</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Racheal Smith</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>no</u> | | | |
| 17. INFORMANT <u>Adell Trower</u> Address <u>Rt #1 366A Landover, Md</u> | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart failure</u> DUE TO <u>1 yr</u> (c) <u>Hypertension</u> INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>434.1</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>Mar</u> , 1957, to <u>May</u> , 1957, that I last saw the deceased alive on <u>May 31</u> , 1957, and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Dr. Henry A. Wise</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>9005 Volta St, Lanham, Md</u> DATE SIGNED <u>4/6/57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Henry A. Wise</u> | | | | City, town, or county <u>Lanham, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>June 5th</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Cape Charles, Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Cape Charles, Va.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Joyner</u> ADDRESS <u>116 Mass. Ave. N.W. Washington, D.C.</u> | | | | 24a. REC'D BY REGISTRAR <u>IN 5</u> | | 24b. REGISTRAR'S SIGNATURE <u>1957 Carrie Campbell</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

See Div. 14

1. Name of deceased (Print or write full name)

2. Date of death (Month, day, year)

3. Place of death (City, town, village, or other locality)

4. Name of physician (Print or write full name)

5. Name of hospital or institution (Print or write full name)

6. Name of attending physician (Print or write full name)

7. Name of medical examiner (Print or write full name)

8. Name of coroner (Print or write full name)

9. Name of registrar (Print or write full name)

10. Name of funeral director (Print or write full name)

11. Name of undertaker (Print or write full name)

12. Name of cemetery (Print or write full name)

13. Name of place of burial (Print or write full name)

14. Name of place of interment (Print or write full name)

15. Name of place of cremation (Print or write full name)

16. Name of place of entombment (Print or write full name)

17. Name of place of inhumation (Print or write full name)

18. Name of place of disposition (Print or write full name)

19. Name of place of disposal (Print or write full name)

20. Name of place of disposal (Print or write full name)

21. Name of place of disposal (Print or write full name)

22. Name of place of disposal (Print or write full name)

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60. Name of place of disposal (Print or write full name)

BUREAU V. S.

JUN 5 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

6715

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06690

Reg. Dist. No.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Allentown</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Allentown</u> | |
| c. LENGTH OF STAY IN 1b <u>38 years</u> | | d. STREET ADDRESS <u>7805-Allentown Rd SE</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7805-Allentown Rd SE</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>John James Ramsay Steed</u> | | 4. DATE OF DEATH <u>June 19 1957</u> | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>June 30, 1903</u> | |
| 9. AGE (In years, months, days) <u>53 yrs.</u> | | 10. IF UNDER 1 YEAR: Months <u>5</u> Days <u>3</u> Hours <u>1</u> Min. <u>5</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Lowe E Steed</u> | | 14. MOTHER'S MAIDEN NAME <u>Helen Gannon</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>289.1</u> | |
| 17. INFORMANT <u>Helen E. Steed, Ramsay #2</u> | | Address <u>Ramsay #2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Angiocardiosis</u> DUE TO <u>Chronic emphysema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic emphysema</u> DUE TO (c) <u>Chronic emphysema</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>289.1</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>James I. Boyd</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED <u>June 19, 1957</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>June 22-57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Sted Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Allentown, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Common Bros. 1661-44th Ave</u> | | 24. RECEIVED BY REGISTRAR <u>John E. Steed</u> | |
| ADDRESS <u>1661-44th Ave</u> | | 25. REGISTRAR'S SIGNATURE <u>H. H. Steed</u> | |
| DATE <u>June 24 1957</u> | | DATE <u>June 24 1957</u> | |

BUREAU V. S.

06691

669

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince George</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT Rainer</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT Rainer</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4222-30th STREET</u> | | d. STREET ADDRESS <u>4222-30th ST.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>James Fulton Suite</u> | | 4. DATE OF DEATH <u>6-23-1957</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug. 10, 1883</u> |
| 9. AGE (In years last birthday) <u>73</u> | | IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>MD</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Steven Suite</u> | | 14. MOTHER'S MAIDEN NAME <u>Alma Hardy</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>220-05-5234</u> | |
| 17. INFORMANT <u>Evac Suite</u> | | Address <u>4222-30th ST MT Rainer MD.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory Failure</u> DUE TO (b) <u>Carcinomatosis</u> DUE TO (c) <u>Melanoma Left Shoulder</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>190x</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>3 years</u> <u>2 1/2 yrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Lymphedema-Left chest mediastinum</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>March 12, 1957</u> , to <u>June 23, 1957</u> , that I last saw the deceased alive on <u>June 22, 1957</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Joseph H. Watson</u> | | DATE SIGNED <u>June 23, 1957</u> | |
| PHYSICIAN'S NAME (Type) <u>Joseph H. Watson</u> | | ADDRESS (Street, city or town, state) <u>Garrett Park, Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>6-26-57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>HOPE CHAPEL</u> | 22d. LOCATION (City, town, or county) (State) <u>EDGEWATER MD.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>WW Chambers</u> | | 24a. REC'D BY REGISTRAR <u>James E. ...</u> | |
| ADDRESS <u>1400 Hope St NW Washington DC</u> | | DATE <u>JUN 25 1957</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 25 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6684

06692

Reg. Dist. No. 242

| | | | |
|---|------------------------|--|-------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capital Heights | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capital Heights | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6120 C Street | | d. STREET ADDRESS 6120 C Street | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Hathe May Swick | | 4. DATE OF DEATH Month Day Year June 15 19 57 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 20, 1883 |
| 9. AGE (In years last birthday) 74 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Grocery Store | |
| 11. BIRTH PLACE (State or foreign country) New York | | 12. CITIZEN OF WHAT COUNTRY? U. S. C | |
| 13. FATHER'S NAME Albert H. Haught | | 14. MOTHER'S MAIDEN NAME Hathe Turn | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 17. INFORMANT Address Clarence Swick, payee as #2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Intra Cranial Hemorrhage DUE TO (b) Cardiovascular renal disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 331X 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE James I. Boyd | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type or print) James I. Boyd | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 15, 1957 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/18/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill | | 22d. LOCATION (City, town, or county) (State) Sulland Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. Rom. Lee sons 300-4th St. N.E., D.C. | | 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Carrie Campbell | |

MAINE STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. B

JUN 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar's name, address, burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06693

6635
CERTIFICATE OF DEATH

Reg. Dist. No. 245

| | | | | | | | |
|--|---------------------------|---|----------------------------------|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale Md | | c. LENGTH OF STAY IN 1b 5 years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/ Riverdale Md. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Good Luck Road | | | | d. STREET ADDRESS Good Luck Road | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Louise Middle Teske | | | | 4. DATE OF DEATH Month June 14, Day 1957 Year 19 | | | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct 20, 1861 | | 9. AGE (In years lost birthday) 95 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY own Home | | 11. BIRTHPLACE (State or foreign country) Germany | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Unknown | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT Vincent A Teske Address 4612 Georgia Ave NW Washington D. C. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 mos | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. 5. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 52, to 6-14, 1957 that I last saw the deceased alive on 6-13, 1957, and that death occurred at 29 M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Leonard Hays | | | | ADDRESS (Street, city or town, state) 5201 Bulb Ave. Hyattsville Md | | | |
| PHYSICIAN'S NAME (Type) 6-15-57 | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/17/57 | | 22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery | | 22d. LOCATION (City, town, or county) (State) Colmar Manor, Maryland. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland. | | | | ADDRESS 24a. REC'D BY REGISTRAR DATE JUN 19 1957 | | 24b. REGISTRAR'S SIGNATURE James Lewis | |

BUREAU A. S.

7561 61 NOV

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6716

CERTIFICATE OF DEATH

Reg. Dist. No.

06694

| | | | | | | | |
|--|------------------------------|---|--|--|---|---|--|
| 1. PLACE OF DEATH o. COUNTY PRINCE GEORGE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY PRINCE GEORGE | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BRANDYWINE | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BRANDYWINE | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION NONE | | | | d. STREET ADDRESS | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) ALBERT W. TOWNSHEND | | | | 4. DATE OF DEATH JUNE 5 1957 Month Day Year | | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH AUG. 21, 1878 | | 9. AGE (In years last birthday) 78 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER | | 10b. KIND OF BUSINESS OR INDUSTRY FARMING | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME JOHN G. TOWNSHEND | | | | 14. MOTHER'S MAIDEN NAME ELIZABETH TOWNSHEND | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT John O. Townshend, Brandywine, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS, GENERALIZED ADVANCED DUE TO (c) SENILITY. | | | | INTERVAL BETWEEN ONSET AND DEATH 1 HOUR 3 YEARS. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 5, 1957 to June 5, 1957 , that I last saw the deceased alive on June 5, 1957 , and that death occurred at Brandywine, Md. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Alfred R. Lapin | | | | ADDRESS (Street, city or town, state) Brandywine, Md. | | | |
| PHYSICIAN'S NAME (Type) ALFRED R. LAPIN | | | | DATE SIGNED 6/6/57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-7-57 | | 22c. NAME OF CEMETERY OR CREMATORY St Pauls Cemetery | | 22d. LOCATION (City, town, or county) (State) Brandywine Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home, Waldorf, Md | | | | ADDRESS Waldorf, Md | | 24a. REC'D BY, REGISTRAR June 10 57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Alfred R. Lapin | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6717

CERTIFICATE OF DEATH

06695

Reg. Dist. No.

242

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH o. COUNTY Prince George's M. MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. XXXX Geo's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillside | c. LENGTH OF STAY IN 1b 12 yrs. | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Hillside | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1325--56th Ave., SE | | d. STREET ADDRESS 1325- 56th. Ave. S.E. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First JEANNE Middle TRON Last TRON | | 4. DATE OF DEATH Month June Day 2nd. Year 1957 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 27- 1868 |
| 9. AGE (In years last birthday) 88 yrs. | | IF UNDER 1 YEAR Months 88 Days 88 Hours 88 Min. 88 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Domestic. | |
| 11. BIRTHPLACE (State or foreign country) Italy | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Henry P. Pascal | | 14. MOTHER'S MAIDEN NAME Ann Poet | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 0 | | 16. SOCIAL SECURITY NO. 0 | |
| 17. INFORMANT Mrs. Lina Di Giulian (Dau.) | | Address 1325- 56th Ave., S.E. | |

| | | | |
|---|--|---|--|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Congestive Heart Failure DUE TO (b) Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 434.1 DUE TO (c) 434.1 | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 434.1 | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 4/19/57 to 6/2/57 , that I last saw the deceased alive on 5/31/57 , and that death occurred at 4A M, from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) 2901 Fairlawn St SE DATE SIGNED 6/2/57 | |
| ACTUAL SIGNATURE David Leonarduzzi M.D. | | PHYSICIAN'S NAME (Type) David Leonarduzzi | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-3-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Waldensian Cemetery | | 22d. LOCATION (City, town, or county) (State) Valdese N. Carolina | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Seimons Bros. | | 24a. REC'D BY REGISTRAR DATE JUN 4 1957 | |
| ADDRESS 1661- Wood Hope Rd. SE WASH. D.C. | | 24b. REGISTRAR'S SIGNATURE Carmie Campbell | |

CERTIFICATE OF DEATH

| | | | | | |
|----------------------------|--|--------------------------|--|----------------------------|--|
| 1. Name of deceased | | 2. Sex | | 3. Age | |
| 4. Date of death | | 5. Time of death | | 6. Place of death | |
| 7. Cause of death | | 8. Manner of death | | 9. Signature of physician | |
| 10. Signature of registrar | | 11. Date of registration | | 12. Place of registration | |
| 13. Name of informant | | 14. Relationship | | 15. Signature of informant | |
| 16. Name of funeral home | | 17. Address | | 18. Telephone | |
| 19. Name of cemetery | | 20. Address | | 21. Telephone | |
| 22. Name of undertaker | | 23. Address | | 24. Telephone | |
| 25. Name of funeral home | | 26. Address | | 27. Telephone | |
| 28. Name of cemetery | | 29. Address | | 30. Telephone | |
| 31. Name of undertaker | | 32. Address | | 33. Telephone | |
| 34. Name of funeral home | | 35. Address | | 36. Telephone | |
| 37. Name of cemetery | | 38. Address | | 39. Telephone | |
| 40. Name of undertaker | | 41. Address | | 42. Telephone | |
| 43. Name of funeral home | | 44. Address | | 45. Telephone | |
| 46. Name of cemetery | | 47. Address | | 48. Telephone | |
| 49. Name of undertaker | | 50. Address | | 51. Telephone | |
| 52. Name of funeral home | | 53. Address | | 54. Telephone | |
| 55. Name of cemetery | | 56. Address | | 57. Telephone | |
| 58. Name of undertaker | | 59. Address | | 60. Telephone | |
| 61. Name of funeral home | | 62. Address | | 63. Telephone | |
| 64. Name of cemetery | | 65. Address | | 66. Telephone | |
| 67. Name of undertaker | | 68. Address | | 69. Telephone | |
| 70. Name of funeral home | | 71. Address | | 72. Telephone | |
| 73. Name of cemetery | | 74. Address | | 75. Telephone | |
| 76. Name of undertaker | | 77. Address | | 78. Telephone | |
| 79. Name of funeral home | | 80. Address | | 81. Telephone | |
| 82. Name of cemetery | | 83. Address | | 84. Telephone | |
| 85. Name of undertaker | | 86. Address | | 87. Telephone | |
| 88. Name of funeral home | | 89. Address | | 90. Telephone | |
| 91. Name of cemetery | | 92. Address | | 93. Telephone | |
| 94. Name of undertaker | | 95. Address | | 96. Telephone | |
| 97. Name of funeral home | | 98. Address | | 99. Telephone | |
| 100. Name of cemetery | | 101. Address | | 102. Telephone | |

RECEIVED
JUN 4 1957
BUREAU V. 5

6686

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06696

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE D.C. b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | | c. LENGTH OF STAY IN 1b D.O.A. | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3 | | | |
| d. STREET ADDRESS 1238 Trinidad Avenue | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Meadow Middle Forster Last Tucker | | | | 4. DATE OF DEATH Month June Day 9 Year 1957 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Colored | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 9-14-16 | |
| 9. AGE (In years last birthday) 40 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitorial service | | | | 10b. KIND OF BUSINESS OR INDUSTRY Custodian | | 11. BIRTHPLACE (State or foreign country) N. Carolina | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Dorsey Napper | | | | 14. MOTHER'S MAIDEN NAME Eva McCullough | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT Address 4609 Addison Rd. Pearl Hendricks Tucker; Beaver Heights, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 816X DUE TO Conditions, if any, which gave rise to immediate cause (b) Severence of thoracic aorta. (a), stating the underlying cause last. DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in automobile in collision with another automobile. | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour 11:50 p. m. 6-8-57 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway | | 20f. (City or town) (County) (State) Glenn Dale, Fr. Geo. Maryland | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE John T. Maloney | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) John T. Maloney, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 9, 1957 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/12/ 1957 | | 22c. NAME OF CEMETERY OR CREMATORY Lincoln | | 22d. LOCATION (City, town, or county) (State) Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John T. Stewart | | | | ADDRESS 30 - H. St., N.E. | | 24a. REC'D BY REGISTRAR DATE JUN 12 '57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Paul Smith | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

JUN 12 1957

BUREAU V. S.

See per in automobile in collision with another automobile.

Severance of thoracic aorta.

Hemorrhage and shock

Hemorrhage

External hemorrhage

Colored

9-11-11

Former

Former

Archie George General Hospital

Archie George

Archie George

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MAKING STATE DEPARTMENT OF HEALTH - BUREAU 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6687 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06697

Reg. Dist. No.

| | | | | | | | | |
|---|--|---|--|--|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale | | | c. LENGTH OF STAY IN 1b 4 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 College Park | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital | | | | d. STREET ADDRESS 1 9612 51st Place | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) Sheree Lee Walker | | | | 4. DATE OF DEATH Month June Day 5 Year 19 57 | | | | |
| 5. SEX Female | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH January 21, 1956 | | |
| 9. AGE (In years last birthday) 1 yrs. | | IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. | | IF UNDER 24 HRS. Hours 1 Min. | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ----- | | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (State or foreign country) District of Columbia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Preston Walker | | | | 14. MOTHER'S MAIDEN NAME Shirley Elwood | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 917.0 | | 17. INFORMANT Father; same address | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 917.0 (b) 2nd degree burns of about 60 % of the body DUE TO (c) ----- | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ----- | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Mother was bathing child in bathtub. Called out of the room. Child opened hot faucet. | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour 7:00 P.M. 6-1- 19 57 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | | 20f. (City or town) (County) (State) College Park Pr. Geo. Md. | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE <i>John T. Maloney</i> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | |
| EXAMINER'S NAME (Type) John T. Maloney, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 6, 1957 | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF June 9, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY Stamford Cemetery | | 22d. LOCATION (City, town, or county) (State) Stamford, N. Y. | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE F. GASCH'S SONS | | | | ADDRESS Hyattsville, Maryland | | 24a. REC'D BY REGISTRAR JUN 10 1957 | | |
| | | | | 24b. REGISTRAR'S SIGNATURE <i>James Severy</i> | | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK
DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|-------------------------------|--|--------------------------|--|
| Name of Deceased | | John T. Wainwright, M.D. | |
| Sex | | Male | |
| Age | | 45 years | |
| Date of Death | | January 21, 1957 | |
| Place of Death | | New York City | |
| Cause of Death | | Heart Disease | |
| Manner of Death | | Natural | |
| Signature of Medical Examiner | | [Signature] | |
| Signature of Coroner | | [Signature] | |
| Signature of Registrar | | [Signature] | |

BUREAU V. S.

JUN 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror's name, to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6688

CERTIFICATE OF DEATH

06698

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Choverly | | | | c. LENGTH OF STAY IN 1b 1 day | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital | | | | e. STREET ADDRESS 34 Brentwood 3715 Quincy St. | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last May E. Walters | | | | 4. DATE OF DEATH Month Day Year June 21 19 57 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 4/19/1882 | |
| 9. AGE (In years last birthday) 75 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work | | | | 10b. KIND OF BUSINESS OR INDUSTRY at home | | | |
| 11. BIRTHPLACE (State or foreign country) Tyron, Pa. | | | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | | |
| 13. FATHER'S NAME Astbury Bryan | | | | 14. MOTHER'S MAIDEN NAME Mary Ellen Snyder | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. 171-07-9936 | | | |
| 17. INFORMANT Address 44513-8 Sunday Riverdale, Md. melvin Earl Walters | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO CORONARY THROMBOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY ARTERIOSCLEROSIS (c) GENERALIZED ARTERIOSCLEROSIS | | | | INTERVAL BETWEEN ONSET AND DEATH 4 weeks 2 years 5 years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0 | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 6/11 1957, to 6/21 1957, that I last saw the deceased alive on 6/21 1957, and that death occurred at 2:30 PM, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Norman Donat Ameau M.D. | | | | ADDRESS (Street, city or town, state) 3503 12th May St DATE SIGNED 6/21/57 | | | |
| PHYSICIAN'S NAME (Type) NORMAN DONAT AMEAU MTRAIPIEN MD. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 6-25-57 | | 22c. NAME OF CEMETERY OR CREMATORY Fair Lincoln Cen. | | 22d. LOCATION (City, town, or county) (State) Colmar Manor, Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ralleys Funeral Home, Mt. Rainier, Md. | | | | 24a. REC'D BY REGISTRAR DATE JUN 25 1957 24b. REGISTRAR'S SIGNATURE W. E. Smith | | | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

BUREAU V. E.

JUN 25 1957

RECEIVED

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Items 1,2 FilmG217 7-2-57 et

6718

CERTIFICATE OF DEATH

06699

Reg. Dist. No. 2456 12

| | | | | | | | |
|--|------------------|--|------------------|---|-----------------|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Prince George</u> | | MARYLAND | | STATE <u>Md.</u> | | COUNTY <u>Prince George</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | TOWN | |
| TOWN <u>Seat Pleasant</u> | | <u>2 yrs</u> | | TOWN <u>Seat Pleasant</u> | | <u>27</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| | | | | <u>1 7272 Kobb St.</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <u>Rosa</u> (Middle) <u>Washington</u> (Last) | | | | (Month) <u>June</u> (Day) <u>25</u> (Year) <u>1957</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <u>F</u> | <u>AA</u> | <u>Widowed</u> | <u>12-9-91</u> | <u>65</u> yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>Domestic</u> | | | | <u>Wash., D.C.</u> | | <u>U.S.A</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>John Ruffin</u> | | | | <u>Annie Anderson</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| | | | | | | | |
| 18. MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| 420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u> | | | | <u>1 day</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE | | | | | | | |
| STATING UNDERLYING CAUSE LAST. DUE TO | | | | <u>15 yrs.</u> | | | |
| (C) | | | | | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While <input type="checkbox"/> et work Not while <input type="checkbox"/> at work | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>2-2</u> , 19 <u>57</u> , to <u>6-23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6-24</u> , 19 <u>57</u> , and that death occurred at <u>10:50 AM</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>O. Schubert Marshall</u> | | | | M.D. <u>2712</u> | | DATE SIGNED <u>6-26-57</u> | |
| ADDRESS (Street, city, town, state) | | | | P St., N.W. | | (State) | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) | |
| <u>BURIAL</u> | | <u>6-28-57</u> | | <u>Washington National Cemetery Ft. Myer Va.</u> | | | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| <u>Out</u> | | <u>Out</u> | | <u>W. Earl Barnes Co.</u> | | <u>1432 4th St. N.W.</u> | |
| DATE <u>JUN 28 '57</u> | | | | | | | |

CERTIFICATE OF DEATH

1. NAME OF DECEASED: *John Doe*

2. SEX: *Male*

3. AGE: *45*

4. DATE OF BIRTH: *Jan 15, 1912*

5. PLACE OF BIRTH: *Boston, Mass.*

6. OCCUPATION: *Teacher*

7. CAUSE OF DEATH: *Heart Disease*

8. DATE OF DEATH: *June 25, 1957*

9. PLACE OF DEATH: *Home*

10. SIGNATURE OF DECEASED: *John Doe*

11. SIGNATURE OF WITNESS: *John Doe*

12. SIGNATURE OF PHYSICIAN: *John Doe*

13. SIGNATURE OF REGISTRAR: *John Doe*

14. SIGNATURE OF CLERK: *John Doe*

15. SIGNATURE OF CHURCH CLERK: *John Doe*

16. SIGNATURE OF BURIAL CLERK: *John Doe*

17. SIGNATURE OF INTERMENT CLERK: *John Doe*

18. SIGNATURE OF FUNERAL HOME: *John Doe*

19. SIGNATURE OF CEMETERY: *John Doe*

20. SIGNATURE OF OTHER: *John Doe*

21. SIGNATURE OF OTHER: *John Doe*

22. SIGNATURE OF OTHER: *John Doe*

23. SIGNATURE OF OTHER: *John Doe*

24. SIGNATURE OF OTHER: *John Doe*

25. SIGNATURE OF OTHER: *John Doe*

26. SIGNATURE OF OTHER: *John Doe*

27. SIGNATURE OF OTHER: *John Doe*

28. SIGNATURE OF OTHER: *John Doe*

29. SIGNATURE OF OTHER: *John Doe*

BUREAU V. S.

JUN 28 1957

RECEIVED

RECEIVED

6689

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06700

Reg. Dist. No.

| | | | | | | | |
|--|------------------------------------|---|--|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN lb 24 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 33 Bladensburg | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital | | | | d. STREET ADDRESS Upshur Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Francis Ivy Middle Brown Last Watson | | | | 4. DATE OF DEATH Month June Day 17 Year 1957 | | | |
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 9, 1919 | | 9. AGE (In years last birthday) 37 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Junk | | 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Ram Brown | | | | 14. MOTHER'S MAIDEN NAME Carrie Press | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Theodore Watson; same address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exhaustion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hemorrhage and shock DUE TO (c) Gunshot wound of abdomen | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot by another person while playing dice. | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 5-25- 19 57 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) yard. | | 20f. (City or town) (County) (State) Bladensburg Pr. Geo. Md. | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE John T. Maloney | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) John T. Maloney, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 18, 1957 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-21-57 | | 22c. NAME OF CEMETERY OR CREMATORY African Bapt. Church Cemetery | | 22d. LOCATION (City, town, or county) (State) Cheriton Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co. 901 3rd St., S. W. | | | | 24a. REC'D BY REGISTRAR JUN 20 '57 | | 24b. REGISTRAR'S SIGNATURE W. Beach | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MISSOURI STATE DEPARTMENT OF HEALTH - BATHHOUSE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|-------------------------------|--|----------------------|--|
| Name of Deceased | | Place of Death | |
| George Deane | | St. Louis | |
| Age | | Sex | |
| 64 years | | Male | |
| Race | | Color | |
| White | | White | |
| Occupation | | Cause of Death | |
| Retired | | Heart Disease | |
| Date of Death | | Place of Burial | |
| June 17, 1957 | | St. Louis | |
| Signature of Medical Examiner | | Signature of Coroner | |
| [Signature] | | [Signature] | |

RECEIVED
JUN 20 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6690

CERTIFICATE OF DEATH

06701

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Prince George MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY PG. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md. | | | | c. LENGTH OF STAY IN 1b 1 Day 20 Min. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George Hospital | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant | | | |
| | | | | d. STREET ADDRESS 1001 61st. Street | | | |
| | | | | f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Wilbur Middle Wilson Last Wilson | | | | 4. DATE OF DEATH Month June Day 4 Year 1957 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Colored | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 8-27-91 | |
| | | | | 9. AGE (In years last birthday) 65 yrs. | | IF UNDER 1 YEAR Months 65 Days 65 Hours 65 Min. 65 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | | | 10b. KIND OF BUSINESS OR INDUSTRY Pa. | | 11. BIRTHPLACE (State or foreign country) Pa. | |
| 12. CITIZEN OF WHAT COUNTRY? Pa. | | | | | | | |
| 13. FATHER'S NAME Dennis Wilson | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. Hortense Wilson | | 17. INFORMANT Wife | |
| | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis of Basal Ganglia (Left) 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c) unknown | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 540.0 Gastric Ulcer | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 2nd 1957 to June 3, 1957 that I last saw the deceased alive on June 3, 1957 and that death occurred at 7:10 P.M. from the causes and on the date stated above. Max M. Herzberg ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE | | | | M.D. | | | |
| PHYSICIAN'S NAME (Type) Dr. Max Herzberg | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF June 8, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet | | 22d. LOCATION (City, town, or county) (State) D.C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. Stewart | | | | ADDRESS 30 H St. NE | | 24a. REC'D BY REGISTRAR DATE JUN 10 57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Overman | | | |

CERTIFICATE OF DEATH

Form 100-10

| | | | | | |
|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. HOME | | b. HOSPITAL | | c. OTHER | |
| 2. NAME OF DECEASED JAMES J. JAMES | | 3. SEX Male | | 4. AGE 65 years | |
| 5. DATE OF DEATH JUN 10 1957 | | 6. TIME OF DEATH 10:00 AM | | 7. PLACE OF DEATH JAMES J. JAMES | |
| 8. CAUSE OF DEATH Cerebral arteriosclerosis | | 9. MANNER OF DEATH Natural | | 10. MEDICAL HISTORY Hypertension | |
| 11. SIGNATURE OF DECEASED JAMES J. JAMES | | 12. SIGNATURE OF WITNESSES JAMES J. JAMES | | 13. SIGNATURE OF DECEASED JAMES J. JAMES | |
| 14. SIGNATURE OF DECEASED JAMES J. JAMES | | 15. SIGNATURE OF DECEASED JAMES J. JAMES | | 16. SIGNATURE OF DECEASED JAMES J. JAMES | |
| 17. SIGNATURE OF DECEASED JAMES J. JAMES | | 18. SIGNATURE OF DECEASED JAMES J. JAMES | | 19. SIGNATURE OF DECEASED JAMES J. JAMES | |
| 20. SIGNATURE OF DECEASED JAMES J. JAMES | | 21. SIGNATURE OF DECEASED JAMES J. JAMES | | 22. SIGNATURE OF DECEASED JAMES J. JAMES | |
| 23. SIGNATURE OF DECEASED JAMES J. JAMES | | 24. SIGNATURE OF DECEASED JAMES J. JAMES | | 25. SIGNATURE OF DECEASED JAMES J. JAMES | |
| 26. SIGNATURE OF DECEASED JAMES J. JAMES | | 27. SIGNATURE OF DECEASED JAMES J. JAMES | | 28. SIGNATURE OF DECEASED JAMES J. JAMES | |
| 29. SIGNATURE OF DECEASED JAMES J. JAMES | | 30. SIGNATURE OF DECEASED JAMES J. JAMES | | 31. SIGNATURE OF DECEASED JAMES J. JAMES | |
| 32. SIGNATURE OF DECEASED JAMES J. JAMES | | 33. SIGNATURE OF DECEASED JAMES J. JAMES | | 34. SIGNATURE OF DECEASED JAMES J. JAMES | |
| 35. SIGNATURE OF DECEASED JAMES J. JAMES | | 36. SIGNATURE OF DECEASED JAMES J. JAMES | | 37. SIGNATURE OF DECEASED JAMES J. JAMES | |
| 38. SIGNATURE OF DECEASED JAMES J. JAMES | | 39. SIGNATURE OF DECEASED JAMES J. JAMES | | 40. SIGNATURE OF DECEASED JAMES J. JAMES | |
| 41. SIGNATURE OF DECEASED JAMES J. JAMES | | 42. SIGNATURE OF DECEASED JAMES J. JAMES | | 43. SIGNATURE OF DECEASED JAMES J. JAMES | |
| 44. SIGNATURE OF DECEASED JAMES J. JAMES | | 45. SIGNATURE OF DECEASED JAMES J. JAMES | | 46. SIGNATURE OF DECEASED JAMES J. JAMES | |
| 47. SIGNATURE OF DECEASED JAMES J. JAMES | | 48. SIGNATURE OF DECEASED JAMES J. JAMES | | 49. SIGNATURE OF DECEASED JAMES J. JAMES | |
| 50. SIGNATURE OF DECEASED JAMES J. JAMES | | 51. SIGNATURE OF DECEASED JAMES J. JAMES | | 52. SIGNATURE OF DECEASED JAMES J. JAMES | |
| 53. SIGNATURE OF DECEASED JAMES J. JAMES | | 54. SIGNATURE OF DECEASED JAMES J. JAMES | | 55. SIGNATURE OF DECEASED JAMES J. JAMES | |
| 56. SIGNATURE OF DECEASED JAMES J. JAMES | | 57. SIGNATURE OF DECEASED JAMES J. JAMES | | 58. SIGNATURE OF DECEASED JAMES J. JAMES | |
| 59. SIGNATURE OF DECEASED JAMES J. JAMES | | 60. SIGNATURE OF DECEASED JAMES J. JAMES | | 61. SIGNATURE OF DECEASED JAMES J. JAMES | |
| 62. SIGNATURE OF DECEASED JAMES J. JAMES | | 63. SIGNATURE OF DECEASED JAMES J. JAMES | | 64. SIGNATURE OF DECEASED JAMES J. JAMES | |
| 65. SIGNATURE OF DECEASED JAMES J. JAMES | | 66. SIGNATURE OF DECEASED JAMES J. JAMES | | 67. SIGNATURE OF DECEASED JAMES J. JAMES | |
| 68. SIGNATURE OF DECEASED JAMES J. JAMES | | 69. SIGNATURE OF DECEASED JAMES J. JAMES | | 70. SIGNATURE OF DECEASED JAMES J. JAMES | |
| 71. SIGNATURE OF DECEASED JAMES J. JAMES | | 72. SIGNATURE OF DECEASED JAMES J. JAMES | | 73. SIGNATURE OF DECEASED JAMES J. JAMES | |
| 74. SIGNATURE OF DECEASED JAMES J. JAMES | | 75. SIGNATURE OF DECEASED JAMES J. JAMES | | 76. SIGNATURE OF DECEASED JAMES J. JAMES | |
| 77. SIGNATURE OF DECEASED JAMES J. JAMES | | 78. SIGNATURE OF DECEASED JAMES J. JAMES | | 79. SIGNATURE OF DECEASED JAMES J. JAMES | |
| 80. SIGNATURE OF DECEASED JAMES J. JAMES | | 81. SIGNATURE OF DECEASED JAMES J. JAMES | | 82. SIGNATURE OF DECEASED JAMES J. JAMES | |
| 83. SIGNATURE OF DECEASED JAMES J. JAMES | | 84. SIGNATURE OF DECEASED JAMES J. JAMES | | 85. SIGNATURE OF DECEASED JAMES J. JAMES | |
| 86. SIGNATURE OF DECEASED JAMES J. JAMES | | 87. SIGNATURE OF DECEASED JAMES J. JAMES | | 88. SIGNATURE OF DECEASED JAMES J. JAMES | |
| 89. SIGNATURE OF DECEASED JAMES J. JAMES | | 90. SIGNATURE OF DECEASED JAMES J. JAMES | | 91. SIGNATURE OF DECEASED JAMES J. JAMES | |
| 92. SIGNATURE OF DECEASED JAMES J. JAMES | | 93. SIGNATURE OF DECEASED JAMES J. JAMES | | 94. SIGNATURE OF DECEASED JAMES J. JAMES | |
| 95. SIGNATURE OF DECEASED JAMES J. JAMES | | 96. SIGNATURE OF DECEASED JAMES J. JAMES | | 97. SIGNATURE OF DECEASED JAMES J. JAMES | |
| 98. SIGNATURE OF DECEASED JAMES J. JAMES | | 99. SIGNATURE OF DECEASED JAMES J. JAMES | | 100. SIGNATURE OF DECEASED JAMES J. JAMES | |

BUREAU V. S.

JUN 10 1957

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6719

CERTIFICATE OF DEATH

06702

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH o. COUNTY Prince Georges' MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges' | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Naylor | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Naylor | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Tanyard Road | | | | d. STREET ADDRESS Tanyard Road | | | |
| e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Lillian Middle Agnes Last Windsor | | | | 4. DATE OF DEATH Month June Day 5th Year 1957. | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Jan. 2, 1884 | |
| 9. AGE (In years last birthday) 73 yrs. | | IF UNDER 1 YEAR Months . Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME John Richardson | | | | 14. MOTHER'S MAIDEN NAME Margaret Ellen Burch | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. | | 16. SOCIAL SECURITY NO. --- | | 17. INFORMANT Thomas Don Windsor Address Naylor, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized DUE TO 8 yrs (c) Diabetes Mellitus 16 yrs | | | | | | INTERVAL BETWEEN ONSET AND DEATH 4 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 331X | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Ther , 19 57 , to June 5 , 19 57 , that I last saw the deceased alive on 3 June , 19 57 , and that death occurred at 11:50 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Upper Marlboro, Maryland DATE SIGNED 6/6/57. | | | | | | | |
| ACTUAL SIGNATURE R. B. Sasscer | | M.D. Upper Marlboro, Maryland | | | | | |
| PHYSICIAN'S NAME (Type) R. B. Sasscer, M. D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/8/57 | | 22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery | | 22d. LOCATION (City, town, or county) (State) Upper Marlboro, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home | | | | ADDRESS Upper Marlboro, Md. | | 24a. REC'D BY REGISTRAR JUN 10 1957 | |
| | | | | 24b. REGISTRAR'S SIGNATURE H. H. Sedwch | | | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | | | | | | | |
|-----------------------|--|-----------------------|--|-----------------------|--|---------------------------|--|-----------------------|--|-----------------------|--|-----------------------|--|-----------------------|--|-----------------------|--|-----------------------|--|------------------------|--|------------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Birth | | Place of Birth | | Usual Residence | | Cause of Death | | Date of Death | | Time of Death | | Place of Death | | Signature of Physician | | Signature of Registrar | |
| John J. Anderson | | Male | | 45 | | 1912 | | Maryland | | Baltimore | | Heart Disease | | June 10, 1957 | | 10:00 AM | | Home | | J. J. Anderson | | J. J. Anderson | |
| Occupation | | Marital Status | | Education | | Religion | | Race | | Color | | Manner of Death | | Certified by | | Date | | Signature | | Signature | | Signature | |
| None | | Married | | High School | | Catholic | | White | | White | | Natural | | J. J. Anderson | | June 10, 1957 | | J. J. Anderson | | J. J. Anderson | | J. J. Anderson | |
| Previous Illnesses | | Previous Injuries | | Previous Operations | | Previous Hospitalizations | | Previous Deaths | | Previous Burials | | Previous Cremations | | Previous Dispositions | | Previous Dispositions | | Previous Dispositions | | Previous Dispositions | | Previous Dispositions | |
| None | | None | | None | | None | | None | | None | | None | | None | | None | | None | | None | | None | |
| Previous Deaths | | Previous Burials | | Previous Cremations | | Previous Dispositions | | Previous Dispositions | | Previous Dispositions | | Previous Dispositions | | Previous Dispositions | | Previous Dispositions | | Previous Dispositions | | Previous Dispositions | | Previous Dispositions | |
| None | | None | | None | | None | | None | | None | | None | | None | | None | | None | | None | | None | |
| Previous Dispositions | | Previous Dispositions | | Previous Dispositions | | Previous Dispositions | | Previous Dispositions | | Previous Dispositions | | Previous Dispositions | | Previous Dispositions | | Previous Dispositions | | Previous Dispositions | | Previous Dispositions | | Previous Dispositions | |
| None | | None | | None | | None | | None | | None | | None | | None | | None | | None | | None | | None | |

BUREAU V. S.

JUN 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06703

6691

CERTIFICATE OF DEATH

Reg. Dist. No. 229

| | | | |
|--|------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Prince George MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel rural | | c. LENGTH OF STAY IN 1b 2 weeks | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hanover | | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sandy Spring Road | |
| d. STREET ADDRESS 02X02 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Janie First Fredelia Youse Last | | 4. DATE OF DEATH June 8, 1957 Month Day Year | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 18, 1885 |
| 9. AGE (In years last birthday) 71 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Franklin Harding | | 14. MOTHER'S MAIDEN NAME Rachel Waters | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. Miss Henrietta Youse Hanover, Maryland | |
| 17. INFORMANT Miss Henrietta Youse Hanover, Maryland | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Liver - Colon 153X DUE TO Transverse Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma Sigmoid (operation 1952) DUE TO (c) Sign PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 6 mo. | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from July 15, 1957 , to June 8, 1957 , that I last saw the deceased alive on June 8, 1957 , and that death occurred at 7:40 P.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE N.B. Steward | | ADDRESS (Street, city or town, state) DATE SIGNED 314 Compin Ave. Landover, Md. 1957 | |
| PHYSICIAN'S NAME (Type) N.B. STEWARD | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/11/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Trinity Meth. Church Cem. | | 22d. LOCATION (City, town, or county) (State) Patuxent, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE De Witt Daralben Russell | | 24a. REC'D BY REGISTRAR 14 1957 | |
| ADDRESS Md. | | 24b. REGISTRAR'S SIGNATURE Mellie Brackley | |

CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|---|--|---------------------------------------|--|--|--|
| 1. NAME OF DECEASED JAMES H. HAYES | | 2. SEX Male | | 3. AGE 70 years | | 4. RACE White | |
| 5. PLACE OF BIRTH Baltimore, Md. | | 6. DATE OF BIRTH May 12, 1887 | | 7. PLACE OF DEATH Baltimore, Md. | | 8. DATE OF DEATH June 14, 1957 | |
| 9. OCCUPATION Retired | | 10. CAUSE OF DEATH Heart Disease | | 11. MANNER OF DEATH Natural | | 12. SIGNATURE OF PHYSICIAN J. H. HAYES | |
| 13. SIGNATURE OF WITNESSES J. H. HAYES | | 14. SIGNATURE OF REGISTRAR J. H. HAYES | | 15. SIGNATURE OF CLERK J. H. HAYES | | 16. SIGNATURE OF DEPUTY CLERK J. H. HAYES | |

BUREAU V. B.

JUN 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6620

CERTIFICATE OF DEATH

06704

Reg. Dist. No.

| | | | |
|--|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3426 Newton Street</u> | | d. STREET ADDRESS <u>3426 Newton Street</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Oliver Florence Ziegler</u> | | 4. DATE OF DEATH <u>June 7 1957</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan. 16, 1871</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Illinois</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Lucius Marion Morris</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Barrett</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>3426 Newton</u> | |
| 17. INFORMANT <u>Edna R. Chapman</u> | | Address <u>Mt. Rainier, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular disease</u> DUE TO (c) <u>10 years</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>321X</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>October, 1950</u> , to <u>June 7, 1957</u> , that I last saw the deceased alive on <u>June 7, 1957</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Charles E. Woodson</u> M.D. | | ADDRESS (Street, city or town, state) <u>1801 Eye St. N.W. Wash. D.C.</u> | |
| PHYSICIAN'S NAME (Type) <u>CHARLES E. WOODSON</u> | | DATE SIGNED <u>6/11/57</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6/10/57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill</u> | | 22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Valley's Funeral Home</u> ADDRESS <u>Mt. Rainier, Md.</u> | | 24a. REC'D BY REGISTRAR <u>JUN 11 1957</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>James Henry</u> | | | |

